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**SERVICE USER-PROFESSIONAL INTERACTION IN HEALTH AND
CARE SETTINGS**

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A thesis submitted in partial fulfilment of the requirements

for the award of Doctor of Clinical Psychology

Coventry University, Faculty of Health and Life Sciences

and the University of Warwick, Department of Psychology

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DECLARATION

This thesis was supervised by Dr Helen Liebling and Dr Simon Goodman and authorship of any papers published from this work will be shared with them.

Apart from the input from my supervisors, this thesis is my own work and it has not been submitted for a degree at any other University. A written summary of the findings from the empirical study will be made available to participants and professionals involved in the study. Service teams will be offered the opportunity to have a short presentation on the findings.

SERVICE USER-PROFESSIONAL INTERACTION IN HEALTH AND CARE SETTINGS

SUMMARY

This thesis is comprised of three chapters written as articles for publication. The theme linking the chapters is the focus on interaction between service users and professionals working in health and care settings.

Chapter one reviews discursive research on health and care professional interaction with people with a learning disability. The focus is on how professionals talk with and about people with a learning disability. Citations are explored which describe professional talk in research interviews, interactions with people with a learning disability in everyday settings, questionnaire-based interviews, therapeutic interactions and meetings. Certain practices have been found to work well in particular contexts and some not so well. There is potential to use practices across contexts, however there is no guarantee that a particular practice will perform the same action in a different interactional setting. Future research in the area could look at the effects of trying to increase the use of some of the more successful practices through staff training.

Chapter two details an empirical study on how questions are used by participants in care programme approach (CPA) review meetings in the NHS. Questions were found to be asked by the professionals at the meeting in a manner that followed the format of a semi-structured interview. Six question types are described in the paper that perform a range of actions; switching topic, prompting the service user, avoiding overt disagreement, bringing the meeting back on topic, offering the service user the opportunity to ask questions and ensuring a particular structure is followed. The analysis suggests that government guidance on CPA regarding service user participation is not being realised in the way that the process is conducted on an interactional level.

Chapter three contains a reflective piece about my experiences conducting discursive research in an NHS setting. It describes the challenges faced in doing research using this methodology and makes suggestions on how some of these potential issues might be tackled.

CHAPTER 1.

HOW DO HEALTH AND CARE PROFESSIONALS TALK WITH AND ABOUT PEOPLE WITH A LEARNING DISABILITY? : A SYSTEMATIC REVIEW OF DISCOURSE ANALYTIC RESEARCH.

This paper has been prepared for submission to the journal ‘Applied Psychological Research’. Further preparation is required in accordance with manuscript guidelines (Appendix A), to ensure it is formatted according to American Psychological Society style. Word count 7,010 (excluding diagrams, tables and references).

Abstract

People with a learning disability often have difficulties communicating with other people. This difficulty can be understood as part of a two way process between the person with a learning disability and the other person. Information on how to communicate more successfully with people with a learning disability would be of use to many health and care professionals. A body of discursive literature exists looking at the way people speak and interact with each other. The current literature review considers what evidence exists about how professionals talk about people with a learning disability and how they talk in interaction with them. The review considers studies that analyse the talk of professionals in research interviews, and interaction with people with learning disabilities in different contexts. Evidence is discussed regarding helpful practices in each of the different contexts and some ideas presented on trying practices in different settings. Limitations of the present review and of the studies included in the review are also considered.

KEYWORDS: Communication; Conversation analysis, Disability, Learning; Discourse analysis, Literature review.

HOW DO HEALTH AND CARE PROFESSIONALS TALK WITH AND ABOUT PEOPLE WITH A LEARNING DISABILITY? : A SYSTEMATIC REVIEW OF DISCOURSE ANALYTIC RESEARCH.

1. Introduction

Communication is a basic human right. This is the view of the British Institute of Learning Disabilities (BILD, 2002). Unfortunately it is not difficult in our society to find examples of people with different communication abilities who have been marginalised or exploited by other people. BILD (2002) recognises that it takes two people to make communication work in any interaction, and this is the subject of the present review. Many people with learning disabilities can and do communicate, as professionals working with people with learning disabilities we are only beginning to learn about our part in the process.

1.1 Communication and Learning Disability

Communication deficits are implied by the current definition of ‘Learning Disability’ put forward by the UK Government Department of Health (DoH) (DoH, 2001; DoH, 2009). This is reflected in the words “a significantly reduced ability to understand new or complex information, to learn new skills (impaired intelligence)” used as one of three points to define the concept (DoH, 2001 p14). In understanding new information, verbal communication is one channel through which the new material reaches an individual with a learning disability. It is reported that 70% of people with a learning disability have some form of difficulty communicating, associated with hearing, listening, understanding and interpreting information (Jones, 2001).

The standard view of a communication or transmission model (Shannon & Weaver, 1949) assumes that there are three main parts of the communication system; the sender of the message, the channel through which the message is sent and the receiver of the message. The lack of an 'ability to understand' on the part of a person deemed to have a 'learning disability' is therefore viewed by this model as a failure of the receiver to understand the message. This model like other positivist psychological theories has been criticised in the past for privileging the individual aspects of communication over the social, interactive aspects (see Kroger & Wood, 1998 on the turn to discourse in social psychology). Locating the problem with communication solely within the person with a Learning Disability has negative consequences, as Goodley (2001, p222) explains; "Assumptions about the origins of 'learning difficulties' have massive impacts upon the treatment of (and research of) people with 'learning difficulties'".

In contrast, a discursive view of language focuses on the way people use talk in interaction to do things in the social world (see Taylor, 2001). This view of language argues that both (or all) parties are involved in the achievement of communication *between* people, rather than the transmission of a message from one individual to another with a 'disability'. Research within the learning disability field has been described as being based upon the "twin objectives of empathising with people's experiences and advocating service change to planners and providers" (Chappell et al. 2001, p47). This view is in sharp contrast with research carried out by people with other forms of disability within the social model of disability (Oliver, 1996). This often focusses on the 'disabling society' and can be more overtly political in nature. Discourse analysis can be understood as occupying a position between research

conducted within the individual and social models of disability. Different discursive traditions can offer ways of “understanding social interaction, minds, selves, sense-making, culture and social relations” (Taylor, 2001). Research within some discursive traditions is grounded in actual interaction so can say something about the everyday lives of people with a learning disability, and how services may be changed to work so they are more helpful for them. These everyday interactions can be seen as a microcosm of wider societal views on learning disability.

Studies looking at the talk-in-interaction displayed when people with a learning disability communicate have shown that their speech has many of the features recognised as being present in the speech of non-learning disabled people (e.g. Yearley & Brewer, 1989). These findings have been used as an impetus to the further use of conversation and discourse analysis in research involving people with a learning disability. This has produced a growing body of knowledge on the interaction of people with learning disabilities with the professionals who work with them in health and care contexts.

1.2 Objectives of the Review

A previous review of the literature on ‘atypical’ conversation in general has been conducted (Antaki, 2012). This review contains conversation analytic research only and is not specific to learning disability. Conversation analytic research on psychotherapy has also been collected in a published volume (Peräkylä et al. 2011). This research centres on the detailed examination of the interactions that occur between psychotherapists and their clients. A recent book by Williams (2011) contains a chapter with a summary of some recent conversation analytic research

relevant to the field of learning disability. The problem for the practitioner working in the learning disability field is that discourse and conversation analytic information may lay outside the literature associated the main professions in health and care. Discourse Analysis is multi-disciplinary, with research conducted within the boundaries of psychology, but also sociology, anthropology and linguistics.

The objective of this review is to provide an aggregation of discursive work that focuses on learning (or intellectual) disability. Bringing this information together in one place will be of use to health and care professionals, who may not be familiar with this body of work. Many services are designed and run specifically for people with a learning disability including community learning disability teams, residential homes and voluntary agencies. As Parry & Land (2013) have noted, the body of conversation and discourse analytic literature is not often read or utilised by practitioners. It is hoped that tailoring the current review to make it specific to the client group that professionals work with will increase accessibility to this knowledge. Another objective of the review is to provide a comprehensive survey of the discursive literature regarding professional talk in learning disability health and care settings. This objective requires that a systematic approach is taken to the literature. In order to achieve this, the review draws on recent guidance that addresses systematically reviewing conversation and related discourse analytic reviews for a healthcare audience (Parry and Land, 2013). The report is organised with reference to guidelines that, although not specifically designed for this type of research, are recommended (Wong et al. 2013).

The focus of the review is on the talk used by professionals working with people with a learning disability in health and care settings. The main question the review will address is what evidence exists about how professionals talk in (1) interaction with people with a learning disability and (2) about people with a learning disability to a third party. The term ‘professionals’ is used throughout this review to refer to people who are in paid employment working with people with a learning disability in health and social care roles, including carers in residential and home care settings. This is in line with the definitions of the word ‘professional’: ‘a person who engages for his livelihood in some activity also pursued by amateurs’ and ‘a person who belongs to or engages in one of the professions’ from the Collins English Dictionary (Collins, 2014).

The term ‘discourse analysis’ covers a range of different approaches to the study of talk and text. This review includes studies which analyse data using conversation analysis, discursive psychology (Potter and Wetherell, 1987; Edwards and Potter, 1992) and critical discursive psychology (Wetherell, 1998). Analyses that draw on these methods all concentrate, to differing degrees, on the fine-grained detail of talk. These analytic approaches focus on talk as social action and so are able to answer the review questions about how professionals talk is accomplished and the cultural resources drawn upon in interaction.

2. Method

2.1 Search Processes

The search terms used were divided into two word groups. Word group one contained; learning disabilit* OR intellectual disabilit*. Word group two contained; discourse OR discursive OR conversation-analysis. Words from the two word groups were connected by the Boolean operator AND during searching.

Included in the review were, (1) studies employing an analytic approach drawing on conversation analysis, discursive psychology or critical discursive psychology. (2) Studies where data are derived from audio or audio-visual data. (3) Studies where professionals (as defined above) talk about ‘learning disability’ or people with learning disabilities. (4) Studies where professionals (as defined above) talk in interaction with people with learning disabilities. Excluded from the review were, (1) studies employing a qualitative analytic approach outside the broad category of ‘discourse analysis’, where the focus was not on the action orientation of the talk. (2) Studies that are primarily based on analysis of textual data (e.g. organisational documents, government policy documents) that are not derived from audio/ audio visual data. (3) Studies employing a discursive analytic approach which have a primary focus on cultural resources used in talk and/or historical and political dimensions (e.g. critical discourse analysis, foucauldian genealogical research). (4) Studies of the talk of professionals (as defined above) from outside the health and social care sectors. (5) Studies of the talk of family members about / with people with learning disabilities in the absence of professionals.

The searches were carried out in four databases; PsycInfo, ASSIA, LLBA and SCOPUS. These databases were chosen to reflect the spread of disciplines in which discursive research can be found, as they represent work from Psychology, Sociology, Linguistics and other Social Sciences. Searches using the terms ‘discourse’ and ‘discursive’ were limited to publication dates after 1987. This decision was based on this being the publication year of Potter and Wetherell’s (1987) seminal work on discursive psychology. Studies using the word discourse or discursive prior to 1987 would be unlikely to be employing the terms in the same vein as those drawing on the analytic methods of ‘discursive psychology’ (Edwards & Potter, 1992) or ‘critical discursive psychology’ (Wetherell, 1998). The terms ‘discourse’ and ‘discursive’ are preferred to the more specific terms ‘discourse analysis’ or ‘discursive psychology’ in order to catch the maximum number of studies using the methods outlined for inclusion. The terms used to describe studies using these analytic approaches have evolved and changed since their first description and continue to do so. The search strategy was designed with the changing landscape of discursive psychology and researcher’s idiosyncratic use of language in mind. In contrast, no time limit was placed on searches that were undertaken using the term ‘conversation-analysis’ in line with the suggestion made by Parry & Land (2013, p6) who argue:

In our view, given the cumulative nature of conversation analytic research, the fact that the term conversation analysis was not used before the 1970’s and the relative stability of communication behaviours, it is

logical to include publications from any date in reviews of conversation analytic evidence.

The term ‘mental retardation’ was considered as a search term alongside the terms in word group 1. This term is primarily used in North America and is not in common professional use in the UK. The intended audience for the review is learning disability professionals in the UK, so the studies included should be relevant to the language used by that group. Although the terms in word group 1 may do subtly different things when used in talk, they are both often used in talk in the UK. The term ‘mental retardation’ has a different history of use and has links with derogatory language such as ‘retard’. Discursive studies are about the social use of language and the use of a term such as ‘mental retardation’ in a review may construct it as a viable alternative to terms currently in use. For these reasons ‘mental retardation’ was not used as a search term.

Studies not published in the English language were excluded, as were studies not in peer-reviewed journals or published books. Following the method of Parry & Land (2013), the peer review process was used as a form of ‘quality control’ on all of the research studies included in the review. Non peer reviewed material was excluded from the review. All theoretical, review and editorial papers were excluded, as were all quantitative and experimental research studies. Studies were also excluded if they were focused on ‘disability’ in general or a specific learning issue (i.e. ASD, dyslexia).

2.2 Data Extraction

Data were extracted from the documents thought to be consistent with the aim of providing a succinct yet comprehensive review to the clinician working with people with a learning disability. Parry and Land (2013, p8) suggest that ‘rather than applying conventional quality appraisal tools, conversation analytic reviewers must collect and present information on several dimensions of the studies’. For the present review this included information on the data used in the study and on the analysis performed. Details of the corpus used including number of recordings, the number and nature of sites, the details of participants (including sex if available) were included to allow the reader to locate each study on these dimensions in order to make their own comparisons. Information on the stated level of learning disability or communication abilities of participants in the studies, the institutional identities and the context of the interaction were extracted. It was thought that this would be information that would make some findings more relevant to certain professionals, for example those working with people with profound learning disability or in a residential setting.

Details on the analysis of data were also extracted and this included information on the data used in the publication, number of transcript extracts, description of the analytic method and the main findings of the study. This information was extracted to allow a multi-dimensional view of the analytic findings to be assessed by the reader. Information on the use of previously described discursive processes and resources in citations was also extracted to provide a further dimension on which to

consider the strength of analysis. Information of use may be gleaned from studies that both focus on a small amount of data in depth and draw on a larger amount of data with a broader analysis.

The included studies were organised according to the context of the interaction under investigation in the study. This allowed the findings from the studies to be collated in such a way that professionals working with people with a learning disability would be able to access information relevant to particular institutional activities in the most convenient way.

3. Results

The results of the search process are shown in Figure 1. The search process returned 30 citations that are included in the review. The studies were assessed on a multi-dimensional basis for quality using the information collated in Table 1 and Table 2, following the approach of Parry & Land (2013). This information was used to decide upon the contribution of studies to the findings reported below.

3.1 Research interviews with professionals.

There were two studies that used data from interviews with professionals and an analytic approach which made use of subject positions and rhetorical strategies (Jingree & Finlay, 2008; Wilcox, Finlay & Edmonds, 2006). The professionals interviewed in both studies were largely described as paid carers or support staff, with a couple of interviewees in one study being unit managers. Talk about empowerment and aggressive challenging behaviour both contained dilemmas for

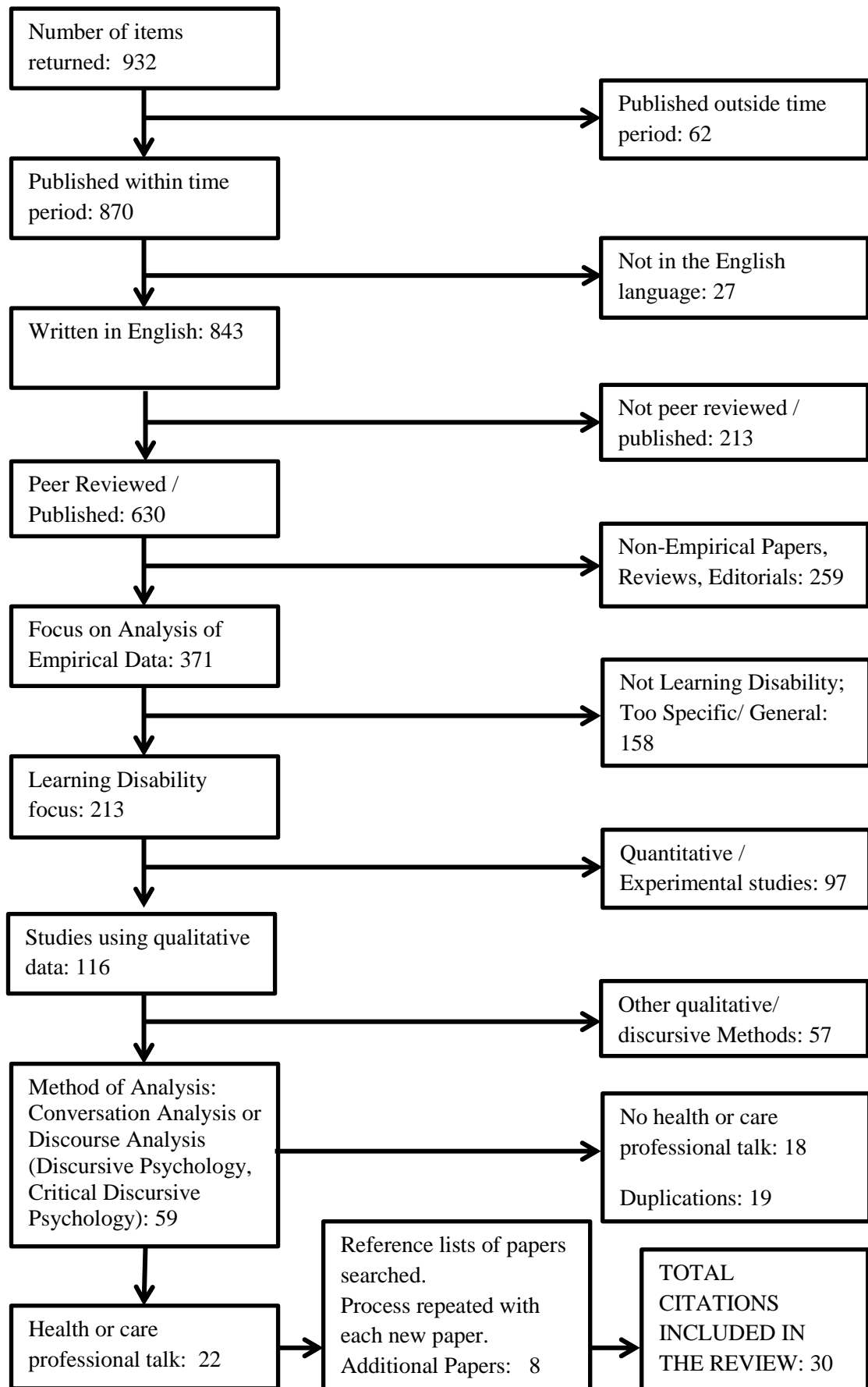


Figure 1. Search Results.

Table 1. Information on the studies included in the review – Data Characteristics.

Study Author and Date	Details of Corpus	Number and Nature of Sites in Corpus	Details of Participants	Nature of Participant LD/ID/ Communication Level.	Institutional Identities of Participants in the Interaction	Context of Interaction
<i>Research Interviews with Professionals</i>						
Jingree & Finlay (2008)	15 Audio recordings of interviews. (60-90 minutes each)	1 service site (UK). Non-NHS provider of residential and day services.	12 female and 3 male staff. 5 Unit Managers.	N/A	Academic Researcher and Support Staff/ Unit Managers	Research Interview
Wilcox, Finlay & Edmonds (2006)	10 Audio recordings of interviews. (60-90 minutes each)	10 service sites (UK). (6 residential services, 2 community support services, 2 day centres).	8 female and 2 male staff. 5 carers of men, 5 carers of women.	N/A	Academic Researcher and Paid Carer	Research Interview
<i>Mundane 'Everyday' Interactions</i>						
Antaki (2013)	Video recordings gathered over a 2 year period (approx. 30 hours in duration).	1 residential service. 1 day service offering supervised gardening activities.	Residential service site: 5 adult men with an ID. Rota of support workers.	Residential service site: Not stated.	Resident (Person with ID) and residential home staff.	Everyday interaction in residential home.
Antaki, Finlay & Walton (2007)	Video and audio recordings gathered over a 9 month period.	2 residential services within one NHS trust (UK).	Residents and staff from one residential home.	Participants had 'comparatively lower support needs and usable language skills'.	Resident (Person with ID) and residential home staff.	Everyday interaction in residential home.
Antaki, Finlay & Walton (2009)	Video and audio recordings gathered over a 9 month	2 group homes (UK). 10 residents in one home and 5	15 people with an ID. 4 staff per shift in one group home.	All residents could communicate verbally to some	Resident (Person with an ID) and Group Home Staff	Everyday interactions in residential group

	period.	in the other.		extent.		homes.
Antaki, Finlay, Walton & Pate (2008)	Video and audio recordings gathered over a 9 month period.	2 residential services within one NHS trust (UK).	5 men with ID. No staff details given.	All participants require support in a range of activities in the home and community. No further clinical information available.	Resident (Person with ID and residential home staff.	Everyday interaction in residential home.
Finlay, Antaki & Walton (2008)	Video and audio recordings gathered over a 9 month period.	2 residential services within one NHS trust (UK).	Not specified.	All residents used only a few words or signs.	Resident (Person with 'severe communication difficulties') and residential home staff.	Everyday interaction in residential home.
Finlay, Antaki, Walton & Stribling (2008)	Video and audio recordings gathered over a 9 month period (approx. 10 hours in duration).	2 residential services within one NHS trust (UK).		All residents have 'significant communication difficulties' and rely on staff for intimate care to 'differing degrees'.	Resident (Person with ID) and residential home staff.	Everyday interaction in residential home.
Rapley (2004)	Corpus original data drawn from not described.	Not described.	Not specified.	Not specified.	Person with an ID and care staff.	Everyday interaction in care settings.
Williams, Ford, Rudge & Ponting (2009)	19 Video Recordings of 14 dyads. (20 hours 30 minutes in total)	N/A (UK).	14 people with an LD. 14 Personal assistants.	12 used verbal language. 2 no verbal language.	Direct Payments Recipient (Person with an LD) and Personal Assistant	Everyday activities in home / community settings.
Williams (2011)	19 Video Recordings of 14	N/A (UK).	14 people with an LD. 14 Personal	12 used verbal language. 2 no	Direct Payments Recipient (Person	Everyday activities in home /

	dyads. (20 hours 30 minutes in total)		assistants.	verbal language.	with an LD) and Personal Assistant	community settings.
<i>Therapeutic Interactions</i>						
Alim (2010)	18 sessions ‘tape’ recorded, 3 sessions analysed following thematic analysis. (duration not specified)	1 service site (UK). NHS Adults with Learning Disabilities Team.	1 man with an LD. 1 Psychodynamic Therapist.	Not described	Person with an LD and Psychodynamic Therapist.	Psychodynamic Therapy Session.
Pote, Mazon, Clegg & King (2011)	4 Video recordings (converted to audio) of 3 family groups plus therapist(s). (duration not specified)	1 service site (UK). NHS ‘Intellectual disability family therapy team’.	2 female, 1 male people with LD. 2 people with LD living in parental home at session with family members. 1 living in supported accommodation in session with partner and two carers. 1 Family Therapist or 1 Trainee in each session.	Not described	Person with an ID, Family Members, Partner, Paid Carer, Family Therapist, Trainee Family Therapist.	Systemic Family Therapy session.
van Nijnatten & Heestermans (2012)	6 Video Recordings of 1 dyad. (average length 60 minutes each)	1 service site; described as a ‘facility’ (Netherlands). 5 sessions in ‘counselling room’. 1 session in clients ‘private room’.	1 woman with LD and history of sexual abuse. 1 Counsellor.	Not described	Client (Person with an LD) and Counsellor	Counselling Session within a residential setting.

<i>Questionnaire-based Interviews with Service Users</i>						
Antaki (1999)	10 recordings of 10 dyads. Interviews part of routine service audit.	1 service site (UK). Psychological Service in Northern England. Clients in supported housing.	10 people with an LD. Interviewers; 2 'psychologists'.	Former residents of long stay institutions. Classified by services as having mild or moderate learning difficulties.	Person with an LD, Psychologists.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
Antaki (2001)	Paper Refers to Antaki & Rapley, 1996b; Rapley and Antaki, 1996 for details of corpus and participants.					
Antaki (2006)	1 Audio Recording of 1dyad.	Not specified (UK).	1 client with an LD, 1 care worker. Both male.	Not specified.	Person with an LD and Care Worker	Service Satisfaction Interview.
Antaki, Houtkoop-Steenstra & Rapley (2000)	12 recordings of 12 dyads. Interviews part of routine service audit.	1 service site (UK). Psychological Service in Northern England. Clients in supported housing.	12 people with an LD. 12 Clinical psychologists.	Former residents of long stay institutions.	Person with an LD and Clinical Psychologists.	'Quality of life' questionnaire based interviews.
Antaki & Rapley (1996a)	10 recordings of 10 dyads. Interviews part of routine service audit.	1 service site (UK). Community Learning Disability Service.	10 people with an LD. 2 interviewers, 1 clinical psychologist and 1 'psychology technician'.	Clients were all 'verbal'.	Person with an LD, Clinical Psychologist, Psychology Technician.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
Antaki & Rapley (1996b)	10 recordings of 10 dyads each approx. 60 minutes in duration. Interviews part of routine service audit.	1 service site (UK). Community Learning Disability Service.	10 people with an LD. 3 Interviewers; clinical psychologist, assistant psychologist, psychiatric nurse.	Clients were all 'verbal'.	Person with an LD, Clinical Psychologist, Assistant Psychologist, Psychiatric Nurse.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
Antaki, Young &	5 Audio recordings	1 service site (UK).	5 people with	Classified by	Person with	Questionnaire based

Finlay (2002)	of 5 dyads. (30-60 minutes each)	Non-NHS trust supported living scheme. Interviews in clients homes.	'learning difficulties' (1 female, 4 male). 5 care staff (1 female, 4 male).	services as having mild or moderate learning difficulties.	learning difficulties and Care Staff	service audit interviews.
Houtkoop-Steenstra & Antaki (1997)	10 recordings of 10 dyads each approx. 60 minutes in duration. Interviews part of routine service audit.	1 service site (UK). Community Learning Disability Service. Interviews carried out in participant's homes.	10 people with an LD. 2 interviewers, 1 clinical psychologist and 1 'psychology technician'.	Referred to Antaki and Rapley (1996b).	Person with an LD, Clinical Psychologist, Assistant Clinical Psychologist.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
Rapley (2004)	Corpus original data drawn from not described.	Not described.	Not specified.	Not specified.	Person with an ID and Psychologist.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
Rapley & Antaki (1996)	8 'tape recordings' of 8 dyads. Interviews part of routine service audit.	1 service site (UK). Psychological Service in Northern England. Clients in supported housing.	8 people with an LD. 2 interviewers, 1 clinical psychologist and 1 assistant clinical psychologist.	Former residents of long stay institutions. Classified by services as having mild or moderate learning difficulties.	Person with an LD, Clinical Psychologist, Assistant Clinical Psychologist.	'Quality of life' questionnaire based interviews (QOLQ; Schalock & Keith 1993).
<i>Service User Meetings</i>						
Antaki (2013)	Video recordings gathered over a 2 year period (approx. 30 hours in duration).	2 service sites (UK). 1 residential service. 1 day service offering supervised gardening activities.	Day service site: 'about 8 clients', 2 Therapists, 2-3 Volunteers, occasionally paid support worker.	Day service site: Not indicated.	Service User, Horticultural Therapist, Volunteers, Personal paid support worker.	'End of day meetings' at day service.
Antaki, Finlay & Walton (2007)	1 Audio recording of 1 meeting (10	1 service site (UK). Residential care	2 staff members present (both	Not specified.	Residents (People with an LD) and	Residents meeting in residential care

	participants).	home.	female). 8 people with an LD present.		Residential Home Staff	home.
Antaki, Walton & Finlay (2007)	4 Video or audio recordings of 4 meetings (number of participants not stated)	3 service sites (UK). 2 Residential homes and 1 day centre.	4 staff members (and the researcher) and 7 people with an LD in meeting extracts.	Not specified.	Residents (People with an LD) and Residential Home Staff	Residents meeting in residential care home.
Finlay, Antaki & Walton (2007)	1 Video recording of 1 meeting, 16 minutes in duration. (7 participants, 1 observer)	1 service site (UK). Group home for people with an LD.	5 participants with an LD (all male). 2 Staff members (1 male, 1 female).	Participants all communicate vocally, but not necessarily verbally. No clinical information available.	Residents (People with an LD) and Staff Members. (Researcher also present).	'House meeting' in a group home.
Jingree, Finlay & Antaki (2006)	2 Audio recordings each 60 minutes in length. (10-12 participants per meeting)	1 service site (UK). Privately run residential care home.	8 people with an LD attending both meetings (6 female, 2 male). 5 Care Assistants, 4 female, 1 male. (4 attending one meeting, 2 attending the other).	Labelled as having mild to moderate LD.	Residents (People with an LD) and Care Assistants	Residents meetings in residential care home.
<i>Service 'Transition' Meetings</i>						
Moya (2009)	13 staff meeting 'recordings' (7 at the hospital, 6 at community home)	2 service sites (UK). Hospital and community home in the midlands of England.	Over 20 nursing staff participants across both settings.	People with ID not included in study. Could not 'communicate verbally'.	Nurses.	Transition meetings for people with complex needs moving from long-stay hospital to community home.
Pilnick, Clegg, Murphy & Almack	Audio recordings of 8 'multi-party	2 service sites (UK). Adjacent	28 young people with an ID and the	Number with ID described as:	People with an ID, Family Carers,	Multi-party intellectual

(2011)	meetings'; 4 transition review meetings, 4 Leaver's 3 month review meetings. 6-10 participants per meeting.	local authorities in England.	networks around them (aged 18-19).	moderate - 3, moderate/severe - 2, severe - 1 and profound & multiple - 2.	Transition co-ordinators, Disabled Persons Act Workers, Connexions Personal Advisors, Teachers, Social Workers, Psychologists, Nurses, Speech Therapists, Day Service Workers.	disability transition review meetings (from child to adult services).
Pilnick, Clegg, Murphy & Almack (2010)	Audio recordings of 8 'multi-party meetings'; 4 transition review meetings, 4 Leaver's 3 month review meetings. 6-10 participants per meeting.	2 service sites (UK). Adjacent local authorities in England.	28 young people with an ID and the networks around them (aged 18-19).	Number with ID described as: moderate - 3, moderate/severe - 2, severe - 1 and profound & multiple - 2.	People with an ID, Family Carers, Transition co-ordinators, Disabled Persons Act Workers, Connexions Personal Advisors, Teachers, Social Workers, Psychologists, Nurses, Speech Therapists, Day Service Workers.	Multi-party intellectual disability transition review meetings (from child to adult services).

Table 2. Information on the studies included in the review – Analysis Characteristics.

Study Author and Date	Data used in the publication	Number of References to data in the publication	Description of Analytic Method	Discursive Strategies / Resources Described	Number of References to Previously Described Discursive Strategies / Resources in the Analysis
Research Interviews with Professionals					
Jingree & Finlay (2008)	Extracts from 4 interviews. Short references from 7 interviews. Data used from 11 interviews in total.	5 Transcript Extracts. 8 Short references in text.	Discourse Analysis; Interpretive Repertoires, Subject Positions, Rhetorical Devices.	Increasing Autonomy	2
				Practicalities Talk	2
				Mixing Increased Autonomy and Practicalities Talk	5
				Risk	2
Wilcox, Finlay & Edmonds (2006)	Extracts from 7 interviews.	12 Transcript Extracts.	Discourse Analysis; Subject Positions, Rhetorical Strategies.	The Individual Pathology Discourse.	3
				The Context Discourse.	1
				Mixing Individual Pathology and Context Discourses	1
				Gendered Discourses. (The menstrual cycle, flawed character)	2
Mundane 'Everyday' Interactions					
Antaki (2013)	Residential service: Extracts involving 1 person with an ID and 1 member of staff.	3 Transcript Extracts	Conversation Analysis	Encouraging reflection by making the client accountable.	3
Antaki, Finlay & Walton (2007)	Extracts involving 4 people with an ID and 4 members of	13 Transcript extracts.	Conversation Analysis	Solicitation of talk from people with an ID: Question pursuit, staff member articulates what resident means, dis-	6

	staff (& 1 researcher).			attending ill formatted material, blunt yes/no repeat of question, test questions, teasing.	
Antaki, Finlay & Walton (2009)	Extracts involving 5 staff and 5 people with an ID.	6 Transcript Extracts	Conversation Analysis	Offering Choice to people with an ID: choice about matters important to the running of the organisation, choice as a format for a running commentary, choice as a format to cover a misfire, choice as a format for refusing an expressed preference, choice as preference among routinized, underspecified or in-principle alternatives.	None referenced.
Antaki, Finlay, Walton & Pate (2008)	Extracts involving 5 people with an ID and 3 staff members (& 1 researcher).	12 Transcript Extracts	Conversation Analysis	Apparently successful ways to offer choice: two option simple alternative in one question, open question & understanding check of answer, open question & immediate multiple-option alternatives, open question & immediate single option, open question repaired to one at a time alternatives, closed yes/no questions.	4
Finlay, Antaki & Walton (2008)	Extracts involving 2 people with an ID and 4 staff members.	11 Transcript Extracts	Conversation Analysis	Service user refusal: acknowledgement and matter dropped, no-blame reissue of invitation, staff dilemma, minimised task, escalation, bodily persuasion, retreat to a more minimal request, reformulation of refusal.	9
Finlay, Antaki, Walton & Stribling (2008)	Extracts involving 1 person with an LD and 1 member of	2 Transcript Extracts. 3 Visual Scenes.	Conversation Analysis	Playing a non-verbal game: interpretation of response, pretending not to like something, pretence of	1

	staff.			indifference to authentic enjoyment. Playing a verbal game: instruction rather than invitation, ambiguity.	
Rapley (2004)	Extracts involving 10 people with an LD.	19 Transcript Extracts.	Conversation Analysis	Staff use of speech patterns that are used when talking to babies or animals; or in parenting. Giving of instructions by staff. Use of a collaborative/ teaching stance by staff.	19
Williams, Ponting, Ford & Rudge. (2009)	Extracts involving 8 people with an LD and 8 personal assistants.	9 Transcript Extracts.	Conversation Analysis	Referring to shared past experience to introduce a topic and keep it going. Referring to shared knowledge to create a joke, using known information about a person to script their talk, shifting to personal life information during professional talk.	1
Williams (2011)	Extracts from 15 personal assistant/ person with an ID dyads.	38 Transcript Extracts.	Conversation Analysis	Challenging disempowering patterns of talk (getting a turn and losing it, not believing what someone says, trying to get accurate information)	9
				Supporting someone to be competent (keeping someone on task, enabling someone to talk about their own support needs, keeping someone safe)	6
				Opening up conversation (giving someone an opener, showing attention to the other person, keeping the talk going, using shared memories, drawing on shared past experiences)	3
				Equalising talk & friendliness (showing that you are friendly, doing something together in a coordinated way, having a social chat about things	3

				you both know)	
				Doing Autonomy (deciding on what to do next, seeking approval, telling people they can choose, joking about choices, deciding without words, discussing pros and cons of choice)	3
				Public encounters (meeting and greeting an acquaintance, expanding on a greeting, requesting a service, being the first speaker, rescuing someone from trouble, scripting and ventriloquism, preparation talk)	2
<i>Therapeutic Interactions</i>					
Alim (2010)	Extracts from 3 sessions with Malan (1979) stage progression.	3 Transcript Extracts.	Discourse Analysis.	Client positioned as ‘the child’, ‘brave/invincible’, ‘the helper’. Therapist positioned as ‘good vs. bad’, ‘the violator’, ‘the lost/dead parent’, ‘the needy’.	None referenced.
Pote, Mazon, Clegg & King (2011)	Extracts from 4 sessions with themes of vulnerability/protection.	7 Transcript Extracts. (4 with family A; 2 with family B; 1 with family C).	Conversation Analysis.	Topic switch	5
				Reversals. Decentring, intensification, continued engagement with the topic of concern.	None referenced.

van Nijnatten & Heestermans (2012)	Extracts from 22 excerpts from the corpus. Excerpts selected as examples of client's agency/empowerment.	5 Transcript Extracts.	Discourse and conversational analysis.	Supporting an active institutional role, (Therapist 'not knowing'), conversational pace, lexical prudence (avoidance of suggestion, planning future action), empowerment.	9
<i>Questionnaire-based Interviews with Service Users</i>					
Antaki (1999)	Extracts from 4 interviews.	5 Transcript Extracts.	Conversation Analysis	Sensitive paraphrasing and lowering threshold for socially positive answering through; nonofficial material apparently ignored, question edited right at the outset, conflation of questions.	3
Antaki (2001)	Extracts from 3 interviews.	3 Transcript Extracts.	Conversation Analysis	Editing a script to reflect a perceived image of a person; Dissembling.	2
Antaki (2006)	Extract from 1 interview.	4 Transcript Extracts	Conversation Analysis	Institutional construction of a 'cognition'.	None referenced
Antaki, Houtkoop-Steenstra & Rapley (2000)	Extracts from 11 interviews.	25 Transcript Extracts.	Conversation Analysis	Use of high grade assessment sequences in the completion of interactional units.	7
Antaki & Rapley (1996a)	Extracts from 8 interviews.	18 Transcript Extracts.	Conversation Analysis	Transformations of questions; paraphrasing linguistically complex items, troubles brought about by pre-questions. Negotiating what counts as the interviewee's answer; pursuing the right answer, ignoring respondents 'irrelevant' material.	7
Antaki & Rapley (1996b)	Extracts from 10 interviews.	18 Transcript Extracts	Conversation Analysis	Motivation for the question asking episode. Motivation of individual	12

				questions. Naturalising the rejection of 'off-track talk'	
Antaki, Young & Finlay (2002)	Extracts from 5 interviews.	19 Transcript Extracts	Conversation Analysis	Departures from neutrality in the interview; assessing respondents answers as reports, offering commentary or advice, 'officialising' upgrading and neutralising, specific candidate answers, limiting the scope of the question.	7
Houtkoop-Steenstra & Antaki (1997)	Extracts from 9 interviews.	19 Transcript Extracts	Conversation Analysis	Reformulation of questions with response options to optimistically framed yes-no questions.	6
Rapley (2004)	Extracts from Interviews	11 Transcript Extracts.	Conversation Analysis	Orientation to interview as a test situation, acquiescence as an artefact, shepherding people to a 'correct' answer, use of echoing and back-channel responses.	16
Rapley & Antaki (1996)	Extracts from 5 Interviews.	12 Transcript Extracts.	Conversation Analysis	Interview oriented to by people with LD as test situation. Acquiescence seen as an artefact of interview interaction.	5
<i>Service User Meetings</i>					
Antaki 2013	Day service: Extracts from 1 meeting.	4 Transcript Extracts.	Conversation Analysis	Use of hinting and elaboration of partial answers to encourage reflection.	2
Antaki, Finlay & Walton (2007)	Extracts from 1 meeting.	1 Continuous transcript extract separated into 7 shorter transcript extracts.	Conversation Analysis	Disempowered identities ascribed to service users during solicitation of their views.	6
Antaki, Walton &	Extracts from 4	11 Transcript	Conversation	Staff proposing activities to people	2

Finlay (2007)	meetings.	extracts.	Analysis	with an LD in ways that suggest they care and are cared for.	
Finlay, Antaki & Walton (2007)	Extracts from 1 meeting.	7 Transcript extracts	Conversation Analysis	Residents non vocal contributions to meetings; instances unnoticed and taken up by staff.	5
Jingree, Finlay & Antaki (2006)	Extracts from 2 meetings.	4 Transcript extracts.	Conversation Analysis	Staff direction of the meeting through; non-uptake of resident's utterances and producing affirmations of service philosophies.	1
<i>Care Review Meetings</i>					
Moya (2009)	Extracts from 2 meetings.	3 Transcript Extracts.	Discourse Analysis; Conversation Analysis	Talk about life story books; establishing mutuality with clients, positioning the life story book in relation to care plans, doing 'personality' work on behalf of the client.	1
Pilnick, Clegg, Murphy & Almack (2010)	Extracts from 8 meetings.	11 Transcript Extracts.	Conversation Analysis	Professional attempts to place young people as active participants, professional questioning style as an interactional impediment to young people, how inadequate participation is dealt with, limits to self-determination.	7
Pilnick, Clegg, Murphy & Almack (2011)	Extracts from 8 meetings.	8 Transcript Extracts.	Conversation Analysis	Conflicts of wishes between parents and young people with an ID through; professionals seeking parental involvement, parents participating freely, parents expressing their own agenda in contrast to young person's.	9

staff. The 'mixing of internal and external obstacles' has been used to describe both of these dilemmas (Jingree & Finlay, 2008). The rhetorical strategy of describing challenging behaviour as individually located pathology and the practicalities talk were seen to draw on internal qualities of the person with a learning disability. In contrast the external environment was brought to the fore by talking about increasing autonomy and describing challenging behaviour as to do with context. In both studies evidence was presented to demonstrate the mixing of the internal and external obstacle discourses in the talk of participants. Jingree & Finlay (2008) make use of a concept in their analysis; the practice/ principle rhetorical device (Wetherell, Stiven & Potter, 1987). This was used by professionals to argue in favour of empowering people with a learning disability in the abstract, while then stating that in practice that this is not possible. This could be utilised as a powerful tool to prevent people with a learning disability exercising their right to make choices about their own lives. The studies demonstrate that professionals working with people with a learning disability orient to the interview with somebody from outside the organisation, i.e. research interviewer, in ways that draw heavily on commonly used cultural resources for understanding the phenomena. Talk on challenging behaviour drew most heavily on the individual pathology discourse, linking the behaviour with something to do with the person with a learning disability. Whilst talk about empowerment focused more on the increasing autonomy discourse which, has been a policy commitment of the UK government for some time (DoH, 2001; DoH, 2009).

The studies both used an interview format with a researcher from an academic background. This method was not acknowledged as potentially affecting the way the participants discussed the work they do with service users. It is possible, however,

that the discourses drawn upon in the conversation with a researcher may be influenced by talking to somebody outside the service. This doesn't invalidate the findings of the studies but is a caution against the suggestion that the particular balance of use of the discourses in each instance may be replicated in other interactional settings. Both studies interviewed professionals who were mainly working in roles of paid carer or support staff. No discursive studies could be found to date that looked at the way that qualified mental health or social care staff talk about people with a learning disability. This raises the question of power and whose talk is studied by discursive and conversational analytic research.

3.2 *Everyday Interactions*

Nine citations were returned that looked at the everyday interactions between professionals and people with a learning disability. The studies were drawn from two major data collections. One corpus of data was collected by Charles Antaki and colleagues and contains interactions that take place in residential homes. The other was collected by Val Williams and contains interactions that are community based and that occur in people's own homes (see Table 1 for more details).

Two studies looking at interaction in residential homes focus on verbal interaction with people who have at least some verbal communication skills. While two studies look at interaction with people with more severe communication difficulties or profound learning disabilities (see Table 2 for details). How the day-to-day negotiation of activities between residential home staff and residents is achieved is

revealed in these articles which focus on the offering of choices by staff to residents (Antaki, Finlay, Walton, & Pate, 2008; Antaki, Finlay & Walton, 2009) and how refusals by residents are made and responded to by the staff (Finlay, Antaki & Walton, 2008). Antaki, Finlay, Walton, & Pate (2008) describe six ways of offering choices to people with learning disabilities and recommendations are made regarding practice. It is suggested that in order that options are clearly presented, offering a list with two options is the optimum for most people. Using physical cues to represent the two options also works well. If there are more than two options, choices were most successfully offered by asking an open question with no options, or narrowing down options presented by the person with a learning disability to two or three and offering those. After a choice is made the rejected option can be offered, followed by the chosen option in order to gauge reaction and increase confidence in the decision.

Antaki, Finlay & Walton (2009) discuss how the offering of choices by residential staff to people with learning disabilities can be used paradoxically to increase the control that staff members have over the situation. In this instance 'choice' becomes something the staff have to be seen to 'do', as directed by policy (DoH, 2001; DoH, 2009). This makes the offering of choices to people part of the way interaction is conducted in the residential home, even in situations where choice is not available or is severely constrained. This is manifested in staff interactions with people with fewer verbal skills who are actively refusing a request (Finlay, Antaki & Walton, 2008). How the staff members talk to the people with a learning disability in such situations suggests a conflict between respecting the choice of the individual to refuse and with the 'duty of care'. This conflict is enacted through on the one hand,

offering repeated invitations to do as requested and reformulation to a smaller request compared with attempts to construct refusal as unacceptable and use of physical force.

The studies on interaction in residential homes are all drawn from the same corpus of data, which, although extensive was collected and analysed by the same group of researchers. Data included in the studies was drawn from one or two residential homes. A wider range of homes studied and the insights of different researchers conducting the studies could increase confidence in the validity of the claims and extend knowledge in this area.

The citations that reference the study of interactions between people with a learning disability and their personal assistants in the community describe different identities that are available within these interactions. For example, the identities of ‘employer’ and ‘employee’ are constructed through these interactions, as the use of direct payments means choice for the person with a learning disability over whom provides support. These positions offer a counter balance to the power relations seen in the residential home, where the power to offer which choices are available is assumed by the staff. A ‘friendly’ way of doing things is described that is achieved through a number of strategies that include references to shared knowledge to create a joke and using shared experiences (Williams, 2009; 2011). Creating a more equalised, relaxed relationship it is argued allows trust to develop and this can aid decision making. As Williams (2011, p105) describes ‘making your own choice is about being trusted and being able to trust yourself, to say what *you* want’. This approach contrasts with the

work of Rapley (2004), which showed the intonation of care staff utterances directed to people with learning disabilities can often mirror the intonation that people use when they address a child or an animal. This intonation was part of an approach to interaction that included staff taking a parental stance towards people with learning disabilities.

3.3 *Therapeutic Interactions*

Three citations were included that looked at professional interaction with people with a learning disability in a therapeutic encounter. One of these studies looked at psychodynamic therapy (Alim, 2010), one systemic family therapy (Pote, Mazon, Clegg & King, 2011) and one addressed the subject of counselling (van Nijnatten & Heestermans, 2012). It is interesting to note that the theoretical orientation of the therapist can be seen reflected in the analytic findings in these studies (see Table 2 for an overview). The study on Counselling concentrated on practices that maintained a conversation characterised by active participation, the article on psychodynamic therapy was concerned with the relationship between therapist and client and the research focused on systemic therapy studied use of questions and who answers these.

Active engagement of the person with a learning disability in counselling is described as being achieved through practices including; showing restraint in suggesting intention in statements or offering interpretations and pacing through the use of long pauses. The silence is described as not being uncomfortable for the client

and has the effect of ensuring that she has a turn to respond. Talk about vulnerability and protection are discussed in systemic family therapy sessions. The central finding was that the topic was switched by a member of the session in order to move away from a difficult conversation, as a protective measure. This strategy was used by different people in the session including parents, siblings and the person with a learning disability themselves.

The study of psychodynamic therapy focused on subject positions taken up at various Malan stages in a case study (Malan, 1979). This study did not link to existing findings in the discursive literature and was reported in a brief format with few extracts that made it difficult to assess the case put forward for the findings. In all three studies, the sessions of therapy were selected as being examples of some factor deemed of interest theoretically to the researchers. The interaction between the theoretical commitments of discourse or conversation analysis and those of the various schools of therapy seemed difficult to negotiate for the researchers. At times the analyses seem to be spotting features which look like elements of therapeutic models, examining the talk in detail and then using this as evidence that the therapeutic technique has this or that effect in practice; in the vein of circular reasoning (in a manner similar to that described by Antaki, Billig, Edwards & Potter, 2002).

3.4 *Questionnaire Based Interviews With Service Users.*

A series of studies have looked at a corpus of data comprised of structured quality of life questionnaires (see tables 1 and 2). Taken together these studies show how psychologists and people with learning disabilities interact to achieve the business of questionnaire completion. Psychologists were found to alter the way that written questions were delivered to people with a learning disability. In delivering questions psychologists paraphrased complex items, asked a series of questions to establish the grounds for the official questionnaire question and negotiated the person's answer (Antaki & Rapley, 1996a). Some questions were identified as being reformulated in an 'optimistic' fashion. This occurred when a list of options for the respondent to choose from was delivered as a yes-no question which strongly invited a positive response and unclear answers were also taken as being positive (Houtkoop-Steenstra & Antaki, 1997). Psychologists were also found to re-phrase questions that dealt with the person with a learning disability's social and personal situation. This editing led to a lowering of the threshold for a positive response (Antaki, 1999). Editing questions that are deemed too brutal can have the effect of treating people as 'socially disabled from the start' (Antaki, 2001, p211) meaning that the scores on questionnaires do not reflect the reality of their lives. It was identified that psychologists made positive comments after respondents had answered certain questions that signal the successful completion of parts of the questionnaire. It is argued that this orients to the institutional demands of questionnaire completion rather than to the content of the clients answer (Antaki, Houtkoop-Steenstra & Rapley, 2000). In a corpus of interactions concerning the completion of service satisfaction questionnaires delivered by staff working for a supported living scheme practices were used that produced inflated answers (Antaki, Young & Finlay, 2002).

These included offering specific candidate answers, offering advice, limiting the scope of the question. Using questionnaire based assessments with people with learning disabilities can produce answers which are inconsistent as it is argued that they often orient to the process as a test or exam situation (Rapley & Antaki, 1996). Trying to get the right answer, in the face of the interviewer reformulating the question in order to achieve a 'correct answer' can be mistaken for acquiescence.

These studies provide a body of evidence that is linked to the wider discursive literature (see Table 2) and based upon many extracts from up to ten interviews (see Table 1). One of the collaborators in the research on quality of life interviews is also one of the participants administering the questionnaires. The dual role of participant and researcher held by a researcher in these studies could be thought of as problematic, because it sets up a circularity where the researcher has an interest in something and then potentially sets out to create that which he is interested in. It is unclear when in the research process the researcher/ participant became involved and to what extent. Discursive research on the administration of other questionnaires /schedules in learning disability services may add further information to the picture on the administration of such measures, in the hope of improving the way these interactions are structured and the quality of information obtained.

3.5 *Service User Meetings.*

There are four studies that look at the interaction between staff and residents at meetings held in residential homes and one that looks at a reflective meeting at a

gardening charity where people with a learning disability attend as an activity. Three studies of meetings in residential homes focus on people able to communicate verbally and one focuses on non-vocal communication. The communications of residents who don't communicate vocally were often not attended to by staff at meetings. People with a learning disability in this context were not attended to by staff when trying to communicate help to another person, alignment with another person, a possible correction, answering a question and giving approval (Finlay, Antaki, Walton & Kliewer, 2007). One example of when a non-verbal gesture is attended to by staff is also included and the positive effects described as being the joint production a particular identity for the resident; 'Guinness man'. The dilemma for staff in these situations is described regarding taking the time to acknowledge the non-vocal communication and developing this into recognition of the person versus continuing with the institutional business of the meeting. Similar interactional sequences where staff 'ignore' residents contributions are seen in meetings with people who communicate verbally (Jingree, Finlay & Antaki, 2006). The stated aim of the meetings in the service was to empower, discuss issues and to facilitate group interaction (Jingree, Finlay & Antaki, 2006). Despite this agenda, staff members were found not to attend to many of the residents communications; instead pursuing agenda items. Practices such as shepherding the residents towards a particular staff approved decision using yes/no questions and providing candidate answers are described as acting against the aim of the meeting and ensure that staff members were in control of what was discussed.

How activities outside the home are offered to people in resident's meetings was found to construct people with a learning disability as being only interested in the social aspects of the event. The way that the activities are offered implies that other criteria are not relevant. This is enacted through the practice of naming a person who will be at the activity or event when it is first proposed (Antaki, Walton & Finlay, 2007). If a resident doesn't respond to, confirm or actively rejects an activity then a person may be named who is also going to attend. The practice of foregrounding social aspects of activities can be positive in terms of maintaining the person with a learning disability in a social network, however it can also be thought of as restricting the information the person has in order to make their choice. In an in depth study of a single extract Antaki, Finlay & Walton (2007b) show how talk in a meeting can move from asking about the views of residents to instructing. This move is shown to take place through asking reformulating questions in the face of an inadequate response from the resident. Candidate answers are offered to the question and practices also seen in educational settings, where the respondent has to finish a sentence, are also used. The episode is described as disempowering to the person with a learning disability.

The use of a meeting at the end of the day to promote reflection at a gardening day activity is described by Antaki (2012). This meeting is the only one included in this review that takes place outside a residential setting. The staff members present at the meeting build upon the answer given by the person with a learning disability; even if it is not understood as a full one. This has the effect of extending the topic that the person was discussing. This is followed by hinting offering clues to help the person

with a learning disability to contribute. The practices described have the effect of being helpful in allowing the person with a learning disability to speak about their experience.

The studies on meetings in resident's homes are drawn from a very limited number of recordings (see Table 1) and the study reporting the reflective group meeting has only four extracts supporting it (see Table 2). More research on meetings in different settings could allow for practices to be described that lead to conversations that promote social inclusion for people with learning disabilities and provide opportunities for more valued identities to be constructed.

3.6 Care review meetings.

There were three citations that looked at meetings held for people with a learning disability at a time of transition between services. Two of the citations contained extracts drawn from the same group of meetings. These meetings investigated the talk at multi-party meetings between child and adult services (Pilnick, Clegg, Murphy & Almack, 2010; 2011). A range of professionals, including those from health and social care are present at the meetings. A further study looks at discussion about life story books in meetings about transition between services for people with complex needs (Moya, 2009).

The studies that focused on transition meetings between adult and child services considered the questions asked by professionals to the young people with a learning

disability (Pilnick et al, 2010) and how professionals manage situations where the young person's opinion is in conflict with the parents opinion (Pilnick et al. 2011). It is argued that professionals use a range of practices that attempt to place the young person in an active role in the meeting. Professionals are described as offering the young person the opportunity to influence the meeting agenda as a question at the start of the meeting, which often is not responded to. It is suggested that control is not handed to the person with a learning disability in the meeting without discussions before the meeting on how this will be achieved. The demands on the professionals in the meeting to come up with a transition plan sometimes leads to questions that are wide ranging over time (past, present and future) and space (different locations). These questions set up situations where the person with a learning disability can give an 'incorrect answer' as defined by the purpose of the meeting.

4. Discussion

4.1 Summary of Findings

Evidence relating to how professionals speak about people with a learning disability is rare. Two recent studies were identified that highlight the way staff contrast what could be done in principle and what is actually achievable in practice. Evidence looking at how professionals speak with people with a learning disability was reviewed according to the context of the interaction. Evidence was located that looked at talk in everyday settings, therapeutic encounters, questionnaire based interviews and in different kinds of meeting.

In terms of everyday interaction, the offering of choices as a two option question has been demonstrated to work well, as has using physical cues in offering choice. Choice in residential settings has been found to be offered by staff where no genuine decision between options is available. Using shared experiences, jokes and shared memories between staff and people with a learning disability can encourage a 'friendly' relationship which can increase active participation by the person with a learning disability in decision making. Therapeutic interactions have been found to work well where the length of pause between questions is longer than would normally be used. In work with families protection of other family members was evidenced through the use of switching the topic of discussion when difficult things were talked about. In the administration of questionnaire based interviews, questions were found to be altered in ways that allowed the answers to be scored in the most positive light. Two option yes/no questions in particular were strongly designed to elicit a positive response. People with a learning disability were found to orient to the interviews as a test situation.

Service user meetings in residential settings were difficult to manage for staff members. Moving the agenda along was prioritised by staff, who were found to direct the meeting and ignore many attempts by residents to contribute. Practices observed at a reflective meeting at a gardening charity show that hinting at an answer, building on an incomplete answer and offering clues can increase involvement in meetings for people with learning disabilities. Young people attending multi-party professionals meetings are often encouraged to take an active role, however some of the practices employed do not support this. It is advised that

control in meetings over the agenda only be offered to young people with a learning disability after prior discussions over how this will occur.

4.2 *Methodological Limitations of Studies Included in the Review.*

The studies included in the review show different limitations when looked at in terms of the breadth and depth of analysis. Some studies that addressed therapeutic interaction did not incorporate the existing discursive literature into their work to the same standard as work by more established discourse and conversation analysts (see Table 2). This represents an issue for the use of discourse analysis in clinical settings. The studies that had clinicians and academics working together produced better analyses when judged on connection to the literature. This is perhaps a good model for future studies in this area.

The size of the corpus for some studies was small, and this may not necessarily represent a problem as both breadth and depth in an analysis can represent quality. However, the literature on residents meetings for example, has studies that focus on depth but no larger scale studies that could add further evidence to how these meetings are structured and the consequences for people with an LD (see Table 1). Focus on in depth analyses rather than collection of large data sets is probably related to the potential difficulties in obtaining meeting data where due regard is given to the ethical issues around consent with people with a learning disability.

4.3 *Strengths & Limitations of the Review.*

This review has attempted to provide an overview of the current discursive evidence on learning disability that will be of relevance to professionals working in health and care settings. The review has utilised the structure of a systematic review and emerging guidance on the process of conducting such a review. As the field of systematic review of discursive literature is in its infancy, the method is not without issues.

The concept of multi-dimensional assessment of quality of studies based on description rather than appraisal as described in Land & Parry (2013) is difficult to implement practically when conducting a review. The authors recommend that ‘two broad dimensions’ be considered concerning ‘type and amount of data and detail and depth of analysis’ (Parry & Land, 2013, pp 8) rather than use of an appraisal system that ranks studies. However, the process of considering these factors necessarily leads to the placing of one study above another in order to organise the content of the review, essentially ranking the studies but without the transparency which a more standard quality appraisal process brings. The concept of systematic reviewing and the field of discourse analysis are not easy to reconcile given the philosophical tensions between positivist and constructionist thinking. The present review is a compromise between both positions in the attempt at a synthesis.

The review is limited by space in reporting the details of the studies, however a strength of the review is in collating the discursive studies on learning disability in

one place and organising them into a format that is more easily approached by professionals working in learning disability services.

4.4 Conclusion & Recommendations.

The present review is not intended to provide definite answers regarding what to say when, however it can provide information that may be valuable to a number of different professionals on interaction in different contexts. The context in which a practice is employed is all important, as the example of yes/no questions demonstrates. Within questionnaire based interviews the simplification of questions to a yes/no format can be used to positively skew results and deny people full information on which to make a decision. However, in everyday settings a yes/no question has been observed to be an acceptable strategy to promote choice for people with learning disabilities through narrowing down the options. Practices may perform different functions in different contexts.

Staff working in residential homes are often engaged in balancing organisational demands against offering choice to residents. The practices used in these settings reflect this dilemma. The potential for some of the practices observed in community settings to be brought into the residential home could be explored, particularly in relation to everyday interactions and conducting reflective meetings. This would require staff training and a pack has been developed on training personal assistants that could potentially be adapted for this purpose (Ponting, Ford, Williams, Rudge & Francis, 2010).

Psychologists and other professionals using questionnaires with people with learning disabilities need to be aware of the consequences of reformulating questions and the potential influence on the data collected. Design of new assessments that make use of the yes/no format in a less positively skewed manner may be possible. Future research would benefit from paying more attention to the everyday talk of other professionals working with people with a learning disability; other than residential care staff and psychologists. The studies reviewed focus predominantly on lower paid care staff. This may be because these people often spend more time with service users or because they represent the least powerful tier of professionals.

Perhaps the most pertinent recommendation that can be made is regarding the discursive method itself. Application of the method or parts of the method, such as audio or video recording (see Finlay, Antaki & Walton 2008 on the use of video) in a service setting can produce locally applicable results that can form part of the reflective development of practitioners. This kind of a process could form a valuable part of delivering the workforce training objectives identified as part of the government's response to the abuse at Winterbourne View Hospital (DoH, 2012, pp 39).

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CHAPTER 2.

THE USE OF QUESTIONS IN CARE PROGRAMME APPROACH (CPA) MEETINGS.

This paper has been prepared for submission to the journal ‘Qualitative Research in Psychology’. Further preparation is required in accordance with manuscript guidelines (Appendix B), to ensure the references are formatted in Harvard style. To provide consistency throughout the thesis this has not been implemented and the paper will be amended later. Word count 7,559 (excluding references).

Abstract

The care of people with complex mental health difficulties in England is organised through a process called the Care Programme Approach (CPA). A key part of the approach is the review meeting where care is planned with the service user and shared decisions are made. Research to date has not addressed how such meetings are actually structured in practice and therefore it is not known if this supports service user participation. The current study uses discourse analysis to investigate the way that questions are used by participants in CPA review meetings. Questions are described that fulfil six functions in the review meeting; switching discussion to a different topic, prompting the service user to add further information, avoiding overt conflict, bringing the conversation back on topic, ensuring that the meeting follows a particular structure, and offering the service user the opportunity to ask questions. The implications of the findings are discussed in relation to service user participation in the CPA process.

KEYWORDS: Communication, Medical, Discourse Analysis, Mental Health & Illness, Healthcare, Teamwork.

1. Introduction

1.1 The Care Programme Approach (CPA)

The care programme approach (CPA) is a system used by National Health Service (NHS) organisations in England to manage the services provided to people with severe and enduring mental health problems. The CPA system of case management was first introduced in 1990 and implemented in 1991 (Department of Health, 1990 cited in Warner, 2005). The latest revision of the good practice guidance regarding the CPA, ‘Refocusing the Care Programme Approach’ (Department of Health, 2008a), mentions the central role that service users and carers should play in the process. The document for service users and carers which accompanies ‘Refocusing the Care Programme Approach’ contains information about reviewing care in the CPA, which commonly takes the form of a meeting (Department of Health, 2008b). These review meetings are the main forum within the CPA where service users and professionals can discuss and engage in decision making regarding the care provided to the service user. The ‘Making the CPA work for you’ document (Department of Health, 2008b) states that service users can choose where, when and with whom they wish to discuss progress and will be supported to take on “whatever level of control you feel able to achieve in setting the agenda and chairing such meetings” (Department of Health, 2008b). A systematic review of randomised controlled trials looking at the effects of shared-decision making (SDM) on the health status and treatment adherence of patients produced mixed results. The review found that only six of the eleven included studies showed a positive effect of SDM over control (Joosten, DeFuentes-Merillas, de Weert, Sensky, van der Staak, de Jong, 2008). However it is worth noting that the studies showing positive effects include the two

studies on mental health conditions (depression and schizophrenia) included in the review. Joosten et al. (2008, p225) conclude that “the available evidence suggests that SDM can be effective in the context of chronic illness and when the intervention contains more than one session.” The criteria cited as suggesting situations when SDM may be effective are almost always fulfilled by people cared for under the CPA.

1.2 Service User Identity

The service users who are subject to the CPA process are those with complex needs. The factors to consider if CPA is needed for a service user include; current high risk, current or severe history of distress, multiple service provision, significant impairment due to mental illness (Department of Health, 2008a). People who have received mental health diagnoses, particularly those with a traditionally poor expectation of recovery (schizophrenia, personality disorder); experience effects on their sense of personal identity (Davidson & Strauss, 1992). The way that people relate to their diagnosis, or ‘illness identity’, has also been found to have an impact on recovery. Yanos, Roe and Lysaker (2010) implicate ‘illness identity’ in many areas of recovery such as; self-esteem, hope, suicide risk, social interaction and symptom severity. In a qualitative study using ethnographic methods, service users with a history of continuing mental health support of 5 years or more described one of the important benefits they derived from woodwork as being development of self-identity (Mee, Sumsion & Craik, 2004).

Service users with complex mental health needs who utilise the CPA can be understood as experiencing challenges regarding their sense of personal identity. The CPA review meeting is a potential site for the co-construction of identity (or identities) through the interaction between clinicians and the service user and carers present. It is also a site where the professionals present interact and engage in identity work. The idea of ‘personal identity threat’ has been put forward to understand the dissatisfaction that people feel about healthcare (Coyle, 1999). Mental health is an area where a focus on risk minimisation is at odds with ‘true patient centredness’ (Pilgrim, Tomasini & Vassilev, 2011, pp143), which may affect trust and increase the likelihood of dissatisfaction with services. This dissatisfaction may be experienced as ‘personal identity threat’ and encompass experiences of being dehumanised, objectified, stereotyped, disempowered and devalued (Coyle, 1999). Under such circumstances relationships between professionals and service users have the potential to contain unhelpful elements such as “conflict, humiliation, exploitation, stress transmission, and unwanted help” (Cohen, 2004 cited in Sani, 2012). Finch, Okun, Pool & Ruehlman (1999 cited in Sani, 2012) suggest that when unhelpful aspects of social relationships are present they sometimes outweigh the benefits. The beneficial aspects of social relationships on health and wellbeing have been demonstrated by a number of studies (see Sani, 2012 for a review).

1.3 Research on the Care Programme Approach.

Research has been conducted looking at compliance with various aspects of the CPA as laid out by government guidance. There has also been research which looks at the experience of service users (for review see Warner, 2005). Much of the research with

service users has been survey based and looks at various 'indicators' of involvement such as; service users knowing who their care co-ordinator is, agreement with care plan, signing care plan (for example McDermott, 1998). Although survey based research can shed light on the extent to which services are fulfilling certain pre-defined criteria; it can not take an in depth look at how these criteria are being fulfilled. How the CPA review meeting functions could have an impact on the level of shared decision making and therefore on outcomes for the service user. Achievement of positive outcomes can be argued to be based on relationships that sustain positive identities that can promote recovery. A study conducted by Hounsell & Owens (2005) looked at the 'barriers and bridges' to care planning within the CPA. This was a piece of service user led research that had a number of recommendations regarding increased user involvement in care planning. Among the factors discussed were time, venue, number of participants at the meeting, structure and communication style (Hounsell & Owens, 2005). For the recommendations made by such research to be realised and implemented, it is necessary to have an understanding of the institutional interactional practices that may support or hinder this aim. A discursive approach can look at how participants at review meetings actually speak to each other and the actions performed by what they say. Discourse analysis has been used to investigate a number of topics in mental healthcare.

1.4 Discursive Research in Mental Healthcare

Hassan, McCabe & Priebe (2007, p141) reviewed studies of mental health professional-patient communication and found that 'few studies investigated two way professional-patient communication'. This is something that has begun to

change in the last few years with more attention paid to, for example, the communication between psychiatrists and people diagnosed with a psychosis (McCabe, Heath, Burns & Priebe, 2002; McCabe & Priebe, 2008). Various forms of Discourse Analysis have been used to look at psychiatric interviews with people diagnosed with depression (Ziolkowska, 2009), the treatment experiences of people diagnosed with an eating disorder (Malson, Finn, Treasure, Clarke & Anderson, 2004) and self –construction in people diagnosed with schizophrenia (Meehan & MacLachlan, 2008). Discursive approaches have also been employed in the study of therapeutic interaction in psychotherapy (for a review see Avdi & Georgaca, 2007; for an edited volume see Peräkylä, Antaki, Vehvilainen & Leudar, 2011).

Although there is little research that addresses talk in meetings within mental health services from a discursive approach, some research has been conducted on care review meetings in learning disability settings. Pilnick, Clegg, Murphy & Almack (2010) looked at questions asked by professionals in transition meetings between child and adult services. They found that although the professionals attempt to promote an active role for the young person in the meeting, questioning practices can sometimes have the opposite effect. Who asks the questions, and how, can have an impact on the meeting process and the ability of the service user to participate. Asking questions in institutional discourse can be linked to power and control over what can be discussed.

1.5 Asking Questions in Institutional Discourse

Drew and Heritage (1992) identify features of talk in institutional settings that are different from those seen in everyday conversation. For example, interactions may be asymmetrical with one party holding more power than the other, there may be specific turn taking rules and there may be restrictions on what people are entitled to say. Institutional talk need not be confined to the physical boundaries of an institution or organisation though, for example, McKinlay & McVittie (2008, p219) suggest that when ‘adopting a focus on institutional talk, analytic focus lies in how interactions are managed in order to accomplish institutional activities.’ Such interactions take place when members of an institution or organisation interact with people from outside the organisation (i.e. customers, service users, carers) as well as with each other. In terms of the CPA, the review meeting is a site of interaction between members of organisations (NHS, other health or social care providers) and the service user and family members who are outside these.

Question asking is a practice where the asymmetry in power between people can be made visible. The view that ‘asking questions amounts to interactional control’ (Eades, 2008 cited in Freed & Ehrlich, 2010) is widely acknowledged in the literature. Institutional roles relate to differential speaking rights (interactional asymmetry), which leads to different levels of interactional control (Freed & Ehrlich, 2010). Workplace meetings have been studied from the point of view of people with different roles within meetings. Freed & Ehrlich (2010) suggest that meeting participants may attempt to exert interactional control in different ways. Looking at the work of Holmes & Chiles (2010) and Ford (2010), Freed & Ehrlich suggest that

‘primary speakers’, such as managers or chairpersons, exert interactional control through directing the flow of conversation in meetings. However ‘non-primary speakers’, such as ordinary meeting attendees (who don’t currently have the floor) can use questions to create opportunities to speak. These opportunities may be taken by the questioner or open the floor to other speakers. Meetings in healthcare settings are carried out within cultures in which relationships between professionals are often hierarchical in nature; with the power differences this implies.

Long, Bonne Lee, & Braithwaite (2008) examined practitioner identity in a multi-disciplinary pressure area clinic in Australia. The study employed an ethnographic approach and one focus was decision making and communication. Team meetings were recorded and examined and a number of issues the team faced in their stated goal of greater ‘clinical democracy’ were found. These issues were the dominance of the medical voice, leadership, valuation of different team member’s time and authority outside the team context. An analysis of one team meeting in the study showed that the medical doctor had the floor for 70% of the time (Long et al. 2008). The study provides an insight into the difficulties faced by professionals in the negotiation of time & space to speak within meetings. If the institutional discourse of healthcare has an impact on the way professionals interact in meetings, then it also has the potential to affect the way people from outside the organisation, such as service users, can join the process.

1.6 Aims of the Current Study

The current study is needed in order to look at the way that participants attending review meetings structure the encounter and how questions are used by service users and professionals. In order to look at the interactional consequences of questions, the response also needs to be considered. This has potential implications for communication between mental health professionals and service users. Improving communication between professionals and service users has the potential to improve outcomes for people with complex mental health needs, influencing their sense of self or identity through the social relationships they have with their treatment team. The current study will add to literatures examining the CPA process and the importance of language use in the construction of personal identity in recovery from severe mental illness. The question addressed by the current study is; how are questions asked in CPA meetings, and what actions do they perform in the interaction between participants.

2. Method

2.1 Procedure

Participants were recruited from three services providing mental healthcare to people currently residing in the community. The services were part of an NHS trust in the midlands of England. Team meetings in the services were attended by the researcher to explain the research to professionals. In total five services were approached, however following attendance at the team meeting two services declined the opportunity to take part in the study. Participant information sheets designed for

professionals (see appendix C) were given to people who were interested in participating at the team meetings, and the opportunity to ask questions given. Interested care co-ordinator participants were given service user participant information sheets (see appendix D) to give to service users who might be interested in participating. Care co-ordinators made contact with the researcher by e-mail to confirm when they had approached an interested service user. Written consent was obtained from all participants at the CPA review meeting (using appendix E). This was done on the day of the meeting before it was due to take place. All participants were offered time with the researcher to ask any questions before the CPA review meeting took place. Meetings were recorded with a digital audio recorder and the researcher withdrew from the room while the meeting was in progress.

Ethical approval was obtained from the Coventry University Ethics Committee (appendix F), and from the NHS local research ethics committee located in Edgbaston (appendix G). Research and Development approval from the participating NHS Trust was also obtained (appendix H).

2.2 Participants

Five meetings were recorded that ranged in length between 20 and 40 minutes. All the meetings had three participants, a psychiatrist, a service user and a care co-ordinator. The care co-ordinator's professional backgrounds were in nursing, occupational therapy and social work. In total the CPA review meetings that were

recorded contained five service users (two women, three men), four psychiatrists (one woman, three men) and four care co-ordinators (all women). Three further service users were approached to take part in the study by their care co-ordinator but declined the opportunity to take part in the study.

2.3 *Method of Analysis*

Recordings were transcribed using the transcription system set out by Jefferson (2004). The transcripts were then analysed using the discursive action model (Potter, Edwards and Wetherell, 1993; Horton-Salway, 2001). For a description of the method used see appendix I. The discursive action model has a focus on the action orientation of talk. Through this focus issues such as stake, interest and accountability can be addressed through close attention to what is said in context. The development of the model was influenced by ethnomethodology and conversation analysis; so it retains an interest in the fine grain interactional processes present in everyday encounters (Potter, 1992). These qualities were considered in choosing this model to analyse the data for this study, as a method was needed that could address the analysis of question and response in the interactional context in which it was said. Through close examination of this context, the action performed by the utterance can be elucidated. An extended section of transcribed material is shown in appendix J.

The discourse action model was chosen over other methods of discourse analysis because it is heavily influenced by conversation analysis and can be used to look in

detail at language use, linking this to social action. Other methods of analysis such as critical discourse analysis focus more widely on the repertoires used in talk and the positions taken up by people within the discourses present. Such an approach is concerned with the use of available cultural resources in the talk of people in interaction. Such a study could yield insights into the positions available to professionals and service users in the CPA meeting and the potential effects on the construction of identity. The current study uses the discursive action model to provide a fine-grained analysis of the use of questions from CPA review meetings, the results of which could be of use to future studies wishing to look at the broader cultural use of particular discourses.

3. Analysis

Six different functions of questions used in CPA review meetings are reported here; switching discussion to a different topic, prompting the service user to add further information, avoiding overt disagreement, bringing the conversation back on topic, offering the service user the opportunity to ask questions and ensuring that the meeting follows a particular structure. In each extract that follows in this section participant 1 (P1) is a psychiatrist, participant 2 (P2) is a service user and participant 3 (P3) is a care co-ordinator.

3.1 Switching Discussion to a Different Topic

The use of these questions by Psychiatrists can be seen on occasions where the Service User is talking about matters that are seen as potentially difficult or not

pertinent to the meeting. Their use seems to be to transition back to the ‘official structure’ of the exchange, allowing the encounter to move along based on more of a semi-structured interview format. In Extract 1 the Service User has been discussing a book that he had been reading about Melanie Klein. The question with a medical focus is indicated by an arrow.

Extract 1: Meeting 2

- 01 P2: But er er I I did find that it sor s s some of the stuff they were talking
02 about sort of made sense
- 03 P1: Okay mmm
- 04 P2: from my [from my experience (.) yeh
- 05 P1: [To ↓yo:u, ahh right okay yeah now I see what you mean yeah
- 06 P2: Er I’m not sure about all the stuff all all the of them lines it’s it’s
07 followed but some of it some of it [certainly seems
- 08 P1: [mmm (1.2) °it seems°
- 09 P2: helpful
- 10→ P1: yeah that’s good °that er mmm° (.) °yeh mmm° (.) °good° Erm ↑and
11 what about the blood test ↑have we had any blood tests
- 12 P2: I haven’t had blood tests for a while

The Psychiatrist starts to speak at line 05 overlapping his speech with the Service User. He attempts to finish the Service Users sentence and states that ‘now’ he understands the Service User. This carries with it the implication that before he didn’t understand but with the extra information the Service User has supplied he gets the gist. It follows then that the discussion of the topic can come to an end if the goal is increasing psychiatrist understanding. This is in agreement with the view of a medic gathering information in order to diagnose and prescribe. The Service User continues to pursue the topic to say that he has found the book ‘helpful’ in what might be construed as a bid to invite follow up questions on how the book links to his experiences. When the Psychiatrist again gets a turn he makes a number of quiet filler utterances before using it to introduce a new topic of blood tests in a clear change of topic away from the one pursued by the Service User. The utterances before the overtly medical question is asked can be seen as ‘delay devices signalling hesitation and a discomfort or reluctance to respond’ (McCabe, Heath, Burns & Priebe, 2002). The medical question allows a swift move away to a safer topic that is more ‘on track’.

A more abrupt example of the use of an overtly medical question to move away from an interaction seen as difficult or off topic can be seen in Extract 2.

Extract 2: Meeting 4

- 01 P3: You've had er another (0.75) unfortunate morning this morning haven't
02 you=
03 P2: =yeah me neighbour (.) er (name of neighbour) overdosed an was on my
04 (1.0) front er my front door this morning in hh a foetal position yeah I've had
05 to get an ambulance out for
06 (5.5)
07→ P1: I'm just wondering about ah those accumulative meds (0.8) your
08 sertraline is one hundred and fifty at the moment=
09 P2: =a hundred and fifty yeh

Here we see the Care co-ordinator introducing the day that the Service User has had as a topic for discussion in the format of a question which opens the floor for him to continue the story. The Service User follows on immediately and gives an account of his difficult morning which means he has had to deal with a distressing situation. The account constructs the Service User as coping well despite challenging circumstances that can't be predicted or planned for. The way that the Care co-ordinator and the Service User collaborate to open up this topic can be construed as a joint bid to direct the conversation. A long pause follows that opens up a position for a response. As the story is already known by the Care co-ordinator and the Service User who have initiated the topic they appear to be awaiting a response from the

Psychiatrist. When the Psychiatrist does respond she disregards the previous utterances and turns to the subject of medication, asking a confirmatory question about dosage. The power to decide what can be discussed is assumed by the psychiatrist and enacted through the practice of asking the questions in an interview-like format.

3.2 *Prompting the Service User to Add Further Information*

The care co-ordinator asks questions that prompt the service user to disclose information which may be useful to proceedings or that allow the service user to speak about a particular topic. An example of this type of question can be seen in Extract 2 (line 01) and a further example is discussed below (Extract 3). We join the conversation at a point where there has been discussion about whether the experience the Service User has around people in public is best characterised as paranoia or anxiety. The Psychiatrist has asked a number of questions in an attempt to discover which of these possibilities offers the correct diagnosis.

Extract 3: Meeting 2.

01 P1: And how does that make you feel when you realise there are [these

02 people

03 P2: [It raises my

04 mood

05 P1: Well okay °mmm°

06 (1.7)

07→ P3: Do you need to take any ↑diazepam on rote

08 P2: No

09 P3: No

10 P2: well I don't take any diazepam, since I think October.

The Care Co-ordinator's question (arrowed) comes after an exchange between the Service User and Psychiatrist. The pause signifies an impasse, as the Service User has given a potentially ambiguous response to the psychiatrist's question. It is unclear what is meant by 'it raises my mood' in this context. The use of this response by the Service User brings the Psychiatrist's questioning to a close and allows the Care Co-ordinator to ask the question to the Service User that acts as a prompt. The Care co-ordinator repeats the answer of 'no' in an act of consensus building, which acts to encourage the Service User to explain his diazepam use further. The information revealed by the Care Co-ordinator's question adds to the exchange that preceded Extract 5 as the use of diazepam expands the information made available to distinguish between anxiety and paranoia.

3.3 *Avoiding Overt Disagreement*

The last sub-section dealt with a situation where Psychiatrist and Service User had reached an impasse in efforts to reach a joint understanding, before the intervention of the Care Co-ordinator with a question that prompted the Service User. In Extract 4, an example is given of the use of a particular question type in order to deal with an impasse in joint understanding that could potentially have led to overt disagreement between the Psychiatrist and Service User. Extract 4 begins as the Psychiatrist has been using a series of questions that require the Service User to be specific about the day to day aspects of his alcohol use.

Extract 4: Meeting 1.

- 01 P1: What, when do you have your first drink.
- 02 P2: Erm (.) well I know on two or three occasions that I've last seen you
- 03 (coughs) I've said eleven o'clock (swallows) erm I've pushed it back to
- 04 about twelve o'clock now (.) so
- 05 (3.0)
- 06 P1: Why do you have it at twelve o'clock=
- 07 P2: =Why do I have it at twelve o'clock (4.3) °er° I don't know cos I want
- 08 one real(hh)ly
- 09 P1: [Arrh but do you start getting erm (.) shakes er

10 P3: [°but why do you°

11 (0.5)

12 P2: No (.) I sorta get (2.0) it's probably dehydration (.) and sort of feel that I

13 need yeh a (.) a can to rehydrate myself but=

14→ P1: =↑So er what other things do you have in the house that you could

15 rehydrate yourself with=

16 P2: =water, [squash, tea

17 P1: [°water, squash, tea yeah°

18 P2: °yeh°

19 P1: °Coffee°

20 P2: °Coffee, yeh°

21 P1: °yeh (.) er can do that°

22 P2: Er can do, I had a cup of coffee this morning yeh.

23 P1: Go for a ↑walk

24 P2: Go for a ↑walk yeah

25 P1: So you're not having any alcohol

26 P2: ↑Yeh

27 P1: Mmm

- 28 (2.4)
- 29 P1: °so°
- 30 P3: It's a long day isn't it really=
- 31 P2: =It is a long day yeh yeah.
- 32 P1: But looking at er (.) how do you do it so your first drink is five o'clock (.)
- 33 not twelve=
- 34 P2: =Mmm fill my time with something else

Extract 4 starts with the Psychiatrist asking questions which require specific answers from the Service User about when and why he has his first alcoholic drink in the morning (lines 01 and 06). This can be seen as a gentler version of the kind of 'nailing down' talk seen in legal settings (Matoesian, 2005). 'Nailing down' is described as 'oppositional talk between adversaries in which both parties are engaged in negotiating what counts as truth' (McKinlay & McVittie, 2008, p178). The Service User answers the first question by appealing to past meetings as evidence of the progress he has made in having 'pushed' the time back when he has the first drink. The Psychiatrist responds with a second question at line 06 that doesn't attend to the account of progress from the Service User, instead asking a further question focussed on detail. The Service User repeats the question with the effect of buying some time and perhaps querying the question as there is a long pause for a possible response from the Psychiatrist. The Service User then claims not to know before offering the answer 'cos I want one really' with a laugh. This

response can be seen as resistance by the Service User to answer the question, avoiding further discussion of the topic. The Psychiatrist then asks about the presence of 'shakes'; a particular physical consequence associated with alcohol dependence. This constructs the Service User as somebody addicted to a substance and so suggests that wanting an alcoholic drink is part of a withdrawal effect and not to do with choice. The service user rejects this suggestion (line 12) and then characterises how he feels as 'probably dehydration', downgrading the more serious suggestion that he is alcohol dependent and making the case that he is suffering simply as anyone would do the morning after drinking alcohol. He goes on to suggest that the alcoholic drink on a morning is to address this dehydration.

Rather than directly challenge the Service User on his response that he has a can because he is dehydrated on a morning, the Psychiatrist responds with a question (line 14); the shift to a more educational stance suggests that the Service User's last response was considered incorrect. The question is asked with a function that appears to be similar to 'test questions' from studies of interactions between pupils and teachers (Edwards & Mercer, 1987). The teacher asks the pupil a question to which the answer is already known by the teacher and expected to be known by the pupil. Test questions have also been identified in the talk between people with a learning disability living in residential homes and care staff (Antaki, Finlay & Walton, 2007). The function of such questions is usually to check understanding, hint towards what is required or to make an issue visible and the person accountable (Antaki, Finlay & Walton, 2007). The alternative to asking a test question here might be for the Psychiatrist to reply in a way that suggests the Service User is trying to

avoid the issue by 'playing dumb'. This would be a much more obvious way of making the Service User accountable for his actions than the subtle use of a test question.

There is an immediate response by the Service User who latches his answer on to the question using a three part list (Jefferson, 1991). A quick response giving further evidence that the answer was known by the Service User as there was no pause in which formulate a response. The Psychiatrist orients to the educational nature of the interaction by repeating each drink in the Service Users response after it has been said and finishing his utterance with a yeah to check understanding. He then suggests a further candidate answer (Pomerantz, 1984) to his own question, which is repeated by the Service User (lines 19-20). The sequence comes to an end with a further suggestion from the Psychiatrist of an activity that could replace the morning alcoholic drink and it's repetition by the Service User. The suggestion 'go for a walk' is repeated by the Service User with the same rising intonation, suggesting he is not sure about the suggestion or possibly mirroring the Psychiatrist as an attempt at consensus building. During the exchange the position of student or instructee has been assumed by the Service User, and in doing so it reduces the expectations on him to know what the 'correct' course of action should be in the given situation. Framing the interaction as an educational encounter allows both the Psychiatrist and the Service User to avoid overt disagreement over why the first drink of the day is consumed.

3.4 *Bringing the Meeting Back on Topic*

The care co-ordinator can intervene at times in the ongoing interaction between the psychiatrist and the service user to bring the meeting back to a topic that has strayed. This is illustrated by the Care co-ordinator's intervention at line 30 in Extract 4. Following a pause and the low volume 'so' from the Psychiatrist, a turn is created for the Care co-ordinator to make an utterance that is taken up as a question by the Service User. The use of 'so' in this context suggests an upcoming formulation (Schegloff, 1972), however the Care co-ordinator makes this, not the Psychiatrist, in the form of a question. The Service User responds with a repetition of the utterance emphasising the word 'is' and answering with 'yeh, yeah'. The response suggests a collaborative consensus between the two about the nature of the Service User's experience. The emphasis given to 'is' can be seen as a demonstration of the endorsement by the Service User to what the Care co-ordinator has said.

3.5 *Offering the Service User the Opportunity to Ask Questions*

Questions asked by service users take place most often in the context of being offered the opportunity explicitly by either the psychiatrist or care co-ordinator. This is illustrated in Extract 5. The extract below is taken from the last few minutes of the meeting.

Extract 5: Meeting 3.

01 P3: is there anything anything we haven't covered [that you think we need to

02 P2: [.hh hh

03 (2.0)

04 P2: I don't think so er >how how< often would would I see you aswell then

05 every couple of months or would you be st stringing that out a bit

The Care Co-ordinator asks the service user if there is anything not covered by the meeting. This question is a delicate one because to respond with an answer of yes may imply that the care co-ordinator and psychiatrist have not asked about something important. This potentially casts them as incompetent, negligent or absent minded. The Service User replies with the preferred response of ‘I don’t think so’, before asking her question. This successfully allows her to manage the implication that the professionals have not covered something while still using the opportunity to ask a question.

3.5 Ensuring that the Meeting Follows a Particular Structure

Asking if the Service User has any questions at the end of a review meeting seems to be a feature that resembles a semi-structured interview. Another similarity with a semi-structured interview format can be seen at the start of each meeting where the first question in the interaction is asked by the Psychiatrist. This starting position sets the structure for the meeting with the Psychiatrist cast as Interviewer, Service User taking the position of Interviewee and the Care Co-ordinator taking up a more peripheral role. Similar questions are used across meetings that appear to follow the

areas discussed in CPA documentation. In order to illustrate the meeting being oriented to as a semi-structured interview; Extract 6 shows a successful attempt by the Psychiatrist to bring the conversation back to a pre-determined schedule.

Extract 6: Meeting 3.

- 01 P2: and she's a clever girl she's lucky she's a bit lazy, doesn't do any studying but
- 02 she's g (.) she will get=
- 03 P1: =get the grades
- 04 P2: yeh (0.7) °yeah°
- 05 (1.0)
- 06 P1: In terms of erm (.) cos we're doing a c cpa rev[iew (P2 name)][so there's there's
- 07 a few
- 08 P3: [yeah
- 09 P2: [yeh
- 10 P2: Right yeh
- 11 P1: I mean we've probably talked about [most the things we need to talk
- 12 P3: [yeah
- 13 P1: about anyway but (1.0) thes a (.) w we run through some headings I guess
- 14 P2: okay
- 15 P1: so in terms of your mental health

- 16 P2: yes
- 17 P3: mmm
- 18 P1: you're still feeling (.) okay
- 19 P2: I do I feel (0.8) g [I feel really good
- 20 P1: [It's been nearly a year now actually

At line 06 in extract 6 the Psychiatrist uses his turn, after a pause, to restate the purpose of the meeting. This restatement comes after the Service User has been discussing her daughter over a number of turns. Restating the purpose of the meetings openly in this way has the effect of doing formal semi-structured interview interaction which is oriented to by the Service User's and Care Co-ordinators initial agreement (lines 08 and 09) before the shift towards a standard question and answer format typical of a standard interview. The Psychiatrist can be construed as assuming control over the structure of the meeting and he does this with a reference to following the 'headings' (line 13) which reference the CPA documents. The statement that most of the ground has already been covered at line 11 and finishing his turn with 'I guess' suggest that the Psychiatrist is displaying doubt about following the structure he has proposed, but that nevertheless this is the way the meeting is to be conducted. The Psychiatrist achieves the transition to a more structured interaction through the adoption of a 'relayer footing' (Levinson, 1988). This conversational footing reduces the responsibility of the speaker for what he says as he is repeating somebody else's words. The psychiatrist makes reference to documents he is reading the headings from that were not written by him, the

implication being that they are not his words; downplaying his accountability for the questions that follow. This process allows the Psychiatrist to manage the situation by both insisting the meeting adopt what is seen as the necessary structure and also that he is not seen as the ‘author’ of the questions he asks. Insisting that the meeting revert to a particular format may prove difficult to manage if the other participants disagree; the use of a relayed footing allows this to occur without disagreement, as the Psychiatrist has successfully reduced his accountability for the action.

4. Discussion

4.1 Summary of Findings

The analysis of six types of questions used in the CPA review meeting can offer an insight into how the business of conducting a CPA review meeting is achieved. The meeting appears to be oriented to by the participants as a semi-structured interview. The format of the CPA review meeting has an interviewer (Psychiatrist) and interviewee (Service User) and the interaction follows a structure where; ‘[i]nterviewers restrict themselves to questioning and interviewees restrict themselves to answering interviewer questions or at least responding to them’ (Clayman & Heritage, 2002 p97). Within this format the Psychiatrist asks most of the questions and some of the functions of these questions have been described in the analysis. The use of questions to switch topic have been demonstrated to be focussed on an overtly medical topic, bringing the conversation back to what the Psychiatrist considers to be the point of the conversation. The use of ‘test questions’ is also demonstrated being used to avoid overt disagreement, moving the interaction from one where details are established to an educational one where the service user is

offered instruction. An educational ‘classroom’ exchange was also noted in the service transition meetings in learning disability settings studied by Pilnick et al. (2010). This usually followed an unsuccessful attempt to allow the person with a learning disability some control over the meeting process by allowing them the floor of the meeting. Psychiatrists and care co-ordinators have also been shown to orient to a set of predetermined questions that form the headings on the CPA documentation. The orientation of the conversation back to this structure occurs in a subtle way that avoids the potential for challenge from other meeting participants. Questions from service users were exhibited when they were offered the opportunity by the psychiatrist or care co-ordinator near the end of the encounter. This practice frames the meeting as one where the main business is the asking of questions by professionals and that service users are offered the opportunity only after this has been achieved. This finding echoes the difficulties in professionals offering service users the floor in a meeting to ask questions reported by Pilnick, Clegg, Murphy and Almack (2010). In learning disability service transition meetings, young people and their parents were offered the floor at the start of the meeting with no prior preparation. This proved a difficult offer to accept in the meeting. How service users are offered control of meetings they are part of and where this occurs in the business of the meeting deserve further attention if their participation is to be fully realised.

Questions asked by the care co-ordinator are displayed performing functions that support the service user to participate in the meeting. Prompting service users to add information and bringing the conversation back to the topic both show the co-ordination implied in the institutional title in action. The care co-ordinator was able

to influence the meeting in subtle ways as demonstrated in the analysis, although it seemed difficult for a third person to adopt a position from which to speak in an interaction framed around an interview format. Given the format, it is difficult to see how care co-ordinators and service users can assume the interactional control necessary to make the idea of service users chairing the meeting, with help from the care co-ordinator, a reality (Department of Health, 2008b).

4.2 Implications for Practice

Particular questions in the meetings had particular outcomes that may or may not be helpful depending on the context. The current study is not intended to be an account of what goes on in the *average* CPA review meeting; it is an analysis of what went on in the CPA review meetings that form the study. Claims are not made that the practices described are representative of all CPA review meetings. However, the questions used and their consequences may be generalizable in the sense that the action performed by the question may be similar elsewhere (Goodman, 2008).

Questions used to switch topic are helpful in keeping the conversation moving, however they can also be delivered in way that is potentially unhelpful. Extract 3 is an example of when the right of the Psychiatrist to ask the questions and decide what is under discussion can potentially stifle the attempts by the service user to assume some interactional control. Use of ‘test questions’ to manage a potential disagreement can help maintain a positive working relationship but this could be at the expense of confronting the service user when they are attempting to avoid talking

about certain aspects of their life. Using pre-printed headings on CPA documentation as questions can ensure that certain information is collected, however it may also make it difficult for participants to challenge the way that the meeting is structured. Asking service users if they have any questions can be done in a way that requires negotiation by the service user before they can accept the offer as seen in Extract 5. The considered use of questions in different circumstances within the meeting would require professionals to be aware of the potential actions they can perform in use. This study provides evidence on some of these possible actions.

The questions asked by the care co-ordinator have observed functions which bring the service user into the conversation to talk about their own experience, while the questions asked by the psychiatrist reference the documentation headings or can find out detailed information. These two styles of questioning are ones that could be developed to represent the consensual world of collective sense making and the individual world of the service user, with two professionals taking on the different positions as is sometimes the case in dialogical network meetings (Seikkula & Arnkil, 2006). This approach may have the effect of bringing greater parity to the voices in the meeting, allowing the care co-ordinator and the service user to take a more active role.

4.3 Methodological Limitations of the Research

Discourse Analysis can be used to look at practices in detail and the local interactional consequences of certain patterns. This can help to clarify what occurs in

institutional settings such as the CPA review meeting. This is useful because the research can address if government policy is being realised at the local level of healthcare practice. However, the research can not describe the extent of the practices described or the thoughts and feelings of the participants. The potential institutional reasons for the way the review meetings are structured and delivered are not fully explored; although further discursive analysis, perhaps using a different model could perhaps look at this question. Although every care was taken to obtain ‘naturally occurring’ data, free from the influence of the researcher, inevitably the recording and consent process did affect data collection. For example, two service user participants made the conversation with the researcher prior to the meeting relevant during the interaction within the meeting. On these occasions interactions between the meeting participants were influenced by the presence of the researcher conducting the consent process. The time scale for the project also affected the number of recordings that could be made, as the process of getting to the point of being able to record was necessarily a long one. This led to a corpus of data that was adequate for the purposes of the present study, but ideally would have contained more meetings to enable greater confidence to be placed in the analysis.

4.4 Recommendations for Further Research

Further research could look at CPA review meetings that have more than the three members that the meetings in the present study contained. The effect of different meeting structures, like having a chairperson designated before the meeting could be investigated to see if the questions asked perform the same functions. It would be interesting to know if the meetings that were studied for the present research were

representative of CPA review meetings, and what potential differences exist. A quantitative language approach could be adopted to code question types and survey their distribution across a sample of meetings. Perhaps CPA meetings could be assessed on measures of active participation by service users before and after the introduction of a new meeting structure, such as a dialogical one, and the effects assessed.

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CHAPTER 3.

“I JUST DON’T UNDERSTAND WHAT THE POINT IS”: REFLECTIONS ON THE EXPERIENCE OF UNDERTAKING DISCURSIVE RESEARCH IN THE NHS.

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Abstract

Reflections on the process of conducting research using a discursive methodology in an NHS setting are described. The main themes discussed include; the challenges in obtaining naturally occurring data, doing research from the positions of ‘insider’ and ‘outsider’ in relation to healthcare services, an NHS culture of risk and safety and health professionals ideas about research. Discursive research is not always well known and understood by health professionals, this can pose problems for the researcher in conducting studies that employ this methodology. Exposure to discourse analysis and the underpinning theoretical ideas through training may improve staff understanding; leading to increased interest in participating in and conducting studies on interaction using these methods.

1. Introduction

The comment that forms part of the title of this paper was made by a Psychiatrist who was part of a mental health team I visited to explain my research to in the hope the team would agree to participate in the study. The comment stayed with me as I felt it said something important about the process of undertaking discursive research in the National Health Service (NHS). The comment was made after I had explained about my study, distributed the participant information and answered questions from other members of the team; in short I felt I had given my best attempt to explain the purpose and relevance of my research. Aside from being personally demoralising to hear that after my efforts somebody still didn't feel they understood the point of the research, I feel it also demonstrates that the underlying philosophies, and therefore the interests and methods of discourse analysis, may be sometimes completely outside the experience of many clinicians working in the NHS. It isn't surprising then that for some health service professionals *research* means something that looks and feels quite different from what a discursive researcher is trying to do.

This paper therefore focusses on reflections of my experiences undertaking a piece of discursive research in the NHS as part of my training in Clinical Psychology. I focus on the main themes that emerged through the research process that have particular relevance within a healthcare context. The study that forms the backdrop for this piece was concerned with the use of questions in care programme approach (CPA) review meetings. The study aim was to look at who asks questions and how in CPA review meetings. Review meetings were audio recorded in community mental health settings in an NHS trust in the West Midlands, transcribed and

analysed using discourse analysis. Mental health professionals including social workers, occupational therapists, and community psychiatric nurses, working as care co-ordinators were recruited as participants in the study through sessions introducing the research to mental health service teams. The Care co-ordinator then made the first approach to the Service user to see if they were interested in taking part in the study.

2. The Pursuit of Naturally Occurring Data

In the planning stages I was keen to structure the study to obtain data that I considered to be naturally occurring; as is consistent with a discursive approach. Within the context of an institutional setting such as a CPA review meeting in a mental health service, naturally occurring refers to what Taylor (2001) describes as ‘talk being uninfluenced by the presence of the observer/recorder’ (p 27). My intention was to minimise the effect that I, as the researcher, would have on the process of the meeting. The digital audio recorder would be present in the room, but I wouldn’t be there in order that during the meeting participants felt able to orient themselves to proceedings in the way that they would usually do. Despite my attempts not to become a part of the meeting process, my presence was alluded to by participants and a conversation I was a part of was even referenced by a service user on one occasion.

Extract 1: Meeting 3 (P1- Psychiatrist; P2- Service User; P3- Care Co-ordinator)

P2: I was saying to Paul, is it?

P3: yeh

P2: that I I've got myself a goal for the future

P1: yes

P2: if I can stay well, if I can do this degree and I've had no episodes or anything I would consider doing something then but probably part time I mean it's a massive thing bipolar you can't just think oh I'll go back to work I'll be fine

Participant two in extract one refers to a conversation I had with her prior to the CPA review meeting as part of the consent procedure. During the opportunity to ask questions about the research, she talked about undertaking a degree in psychology which was made relevant by the nature of my training in clinical psychology. The conversation during the consent process is made relevant in the meeting by the service user in discussing her goals for the future. In this extract, I, as the researcher have become a part of the meeting through the necessary process of obtaining informed consent. It is possible that in Extract 1 the service user is attempting to prevent her goal being challenged by the other meeting participants through reference to her previous conversation with me. Given that psychologists work in mental health settings and that they may be seen as having status and influence, the psychological researcher may also be imbued with such qualities. Conversations that are conducted as part of the informed consent procedure may be infused with power that carries rhetorical weight when referred to in the interaction of interest to the discursive researcher. On reflection, my position regarding the nature of 'naturally occurring' data is now closer to that of Speer (2002) who argues that all situations

can be seen as both natural and contrived. The recordings were about people ‘naturally’ doing the business of CPA review meetings, which in themselves could be considered an institutionally ‘contrived’ situation, that were ‘contrived’ further by research processes like recording and informed consent.

3. Being an ‘Insider’ and Being an ‘Outsider’

Through the process of visiting services to explain my research to teams and recruit Care Co-ordinators as participants, I became aware of the pros and cons associated with being a researcher undertaking research in a mental health setting, whilst also being a mental health professional. Being an ‘insider’ in the world of mental health had benefits in terms of having some knowledge of the general structure of mental health services, the roles and backgrounds of professionals, and the nature of any potential barriers to participation in the study. These benefits were invaluable in being able to access and arrange meetings with teams and there were often people who were interested and saw the potential of the study. I was also able to use professional contacts and people who my contacts knew to gain access to the teams. Indeed, there could potentially be a benefit to actually conducting this kind of research as part of a team. If I had been conducting the research as a clinical psychologist working within the team, this may have increased the enthusiasm for being a participant in the research. I found that the first response of care co-ordinators to being recorded was often to reject it as something they would find too unsettling. I found that after recruiting one care co-ordinator in a team, I would attend to do the recording and somebody else would ask what I was doing and that led to another recording. The trust developed in one-to-one conversations and word

of mouth was important in recruitment. Recording can be an uncomfortable process and the CPA review meetings show you in the process of interacting with service users; part of your job as a professional. This is quite different from agreeing to an individual research interview. The professional members of the meeting were essentially opening up their practice to potential scrutiny. This requires a large degree of trust in the person conducting the research. The trust that colleagues already have in a functioning team could make discursive research a fruitful enterprise for whole staff teams in healthcare to embark upon, it may actually act to strengthen the working relationships in the team as an outcome.

Being 'inside' the NHS, the mental healthcare system, and a specific team can have benefits but can also have drawbacks. The professional groups that make up healthcare services have particular histories, philosophies and inter-relationships. Being a member of one of the mental health professions means that inevitably you carry preconceived ideas into any interaction in terms of the perceived or actual position you occupy. Being part of a study by a clinical psychologist then could be seen as privileging a particular viewpoint or serving the interests of that profession at the expense of others like psychiatry or nursing. This kind of political issue, which might be seen played out in discursive research, can potentially be obscured by an 'insider' researcher. An academic 'outsider', such as a sociologist or anthropologist may be able to be viewed as politically disinterested in terms of the internal relationships within a mental health service by a staff team. However, as members of our particular culture we all have a stake in healthcare and the NHS. Whether inside or out, we all have a position as citizens who pay and potentially use the services

provided by the NHS making the relationship we have with it a political one. Sometimes being a part of a culture can make certain parts of it taken for granted or ‘invisible’ to you. This is where I found having a supervisor who works as an academic psychologist helpful. It was surprising to be looking at the data and asked about what certain features were that I had glossed over or deemed uninteresting. Perhaps, the best combination for this kind of work is to have clinical and academic researchers collaborating so that the research can benefit from the best of both worlds. The experience of having two supervisors for the research I conducted, one academic and one with a clinical background, was of help in negotiating the ‘insider’ and ‘outsider’ positions and getting the best from both.

4. Culture of Risk & Safety

The NHS and in particular, mental health services by their nature are required to be preoccupied by safety and risk reduction in relation to the people who use their services and in some instances the wider public. This can be a legitimate function of their role, but a culture of risk and safety can also raise issues in the conduct of research. In terms of conducting discursive research I was interested in collecting data that were as close to what would usually occur in a CPA review meeting as possible. As part of the recruitment process, care co-ordinators made the first approach to service user participants about potential involvement. The selection of which service users were suitable was left with the care co-ordinator and the wider clinical team. This process was designed with the idea of allowing the team to make decisions about the ability of people to be able to consent to take part. However it is open to the risk that professionals could choose not to ask service users who are able

to consent but may disagree with their care or potentially embarrass the individual professional or the service. The result being that access is granted by the clinicians to a sub-set of meetings that are chosen by them as being acceptable. Indeed, this kind of professional veto on participation may still occur even if all eligible service users were asked to participate as each professional must also give their consent before a meeting can be recorded. The potential risk being attended to here is the risk to the professional; which is tied in with a threat of surveillance currently being felt by some in the NHS due to recent scandals like Stafford Hospital and government reorganisation.

I was given cause to reflect on the nature of the risk felt by clinicians in terms of being under professional surveillance by a comment made by a member of staff at a team meeting I was attending to explain the research. Having explained the recording of the meetings she asked me if I was working for 'Panorama' or 'Dispatches'. This was treated as a joke by her and her colleagues. However the risk that being recorded doing your job conjures up appears to be the same as being filmed by Panorama; being exposed, blamed and your competency questioned. The pressure apparently felt by health service staff to appear competent places them in a position where they may select uncontroversial service user participants to take part in a 'good' meeting. The NHS Trust I collected data from was undergoing a restructure and that change may account for some of the fear of surveillance, however I feel that it was perhaps just a more heightened expression of a more general fear amongst NHS clinicians. Recent inquiries like the one at Stafford Hospital have meant that the competence of health professionals is under scrutiny in

the media and the feeling I had got whilst conducting my research was that there is a reluctance to risk having your own or your service's competency questioned. Research, like discursive studies, that look at what clinicians say and do can be construed as threatening because clinicians are made a part of what is under study. Traditionally the 'studied' in health settings are the service users not the staff. This conjures an idea of the 'invisible clinician' in healthcare; with improvements coming from the study of service users because they are the people who are ill. People are more familiar with a concept of illness being something which is individually located and therefore the 'ill' are the people who need to be studied. This view is particularly problematic in mental health, where the very concept of diagnosis is contested and psychological and social understandings of people's issues are well developed.

A minority of service users who were given a participant information sheet declined to take part, those that did take part were enthusiastic about the research. This could have been due to the selection of participants by the care co-ordinator, but what was interesting was they seemed to grasp the potential use of the study more easily than some professionals. I had assumed that the reverse might be true, so I reflected on why this might be the case. Potter (2005) describes a discursive psychological approach as one built on five main points; psychology as practical, accountable, situated, embodied and displayed. The discursive psychological approach is argued as one that, through these five points, makes psychology relevant to people by focussing on 'psychology from the position of participants' (Potter, 2005 p740). Perhaps the service user participants in the research I undertook saw the relevance,

from their position, of looking at the CPA review meeting in detail. Clinicians through their training and expertise claim access to knowledge and understanding and through this comes power. Any study that examines the way interaction unfolds can also serve to foreground the power relations between the participants. This is potentially uncomfortable for health professionals working in what they see as a ‘caring profession’, where power may not always be acknowledged or made visible. Making psychology relevant to the people who use mental health services seems to be a particular strength of discursive methods and this is achieved through the topics and interests of researchers using these approaches. However, factors like the methodologies and terminology used can make dealing with discursive research rather hard to negotiate. It is to this point, introduced at the start of this paper that I now turn.

5. Ideas About Research.

When I attended the NHS ethical review meeting to discuss my research, I sat in front of the committee and had to explain my proposal. It was striking to me that I sat before a room of people, the majority of whom were NHS professionals, but was asked no questions by them. The only members to ask questions were the lay members, who were in agreement with the idea of looking in detail at the interaction between clinicians and service users. One of the lay members made a comment that ‘discursive research was a rare and exotic beast’, he went on to say that they don’t review many studies using this kind of approach. I felt that this information helped me to make sense of the largely silent response to my proposal. Being unfamiliar with the methods used and the, often, social constructionist philosophies that

underpin discursive approaches can make it difficult to engage with the research. I remember having to concentrate and study hard on my undergraduate course where I was first introduced to discourse analysis. The number of different traditions, all using slightly different terminology and different focus on fine-scale processes versus large-scale cultural resources can be overwhelming. The area is not one that is immediately clear and easy to understand. I had studied Biology before coming to Psychology so I was familiar with the standard experimental approach of science. It took a concerted effort to learn a different way of thinking and approaching research, and for a while discourse analysis didn't make much sense to me. I can understand then that for most clinicians in the NHS; research means experimental studies or possibly finding out about people (usually service users) experiences. Perhaps the development of local expertise in discursive research at one ethics committee within a region would help both researchers and committee members to ensure that the ethical process is informed and robust.

This state of affairs makes explaining the rationale and the potential benefits to teams of NHS professionals and ethics committees a tricky one. I visited a few teams who did not take up the opportunity to participate in the study and some of my interactions with professionals in those teams stand out as exemplifying this issue. At one team meeting, after explaining the research I answered a few questions and attempted to expand the explanation to include some details of what the analysis might entail. At one point I found it difficult to explain my position in a succinct way without using terminology that could be alien to the team. One of the participants commented that 'how am I supposed to explain this to my patient if I can't

understand it now'. I felt that this was a fair point and unfortunately one that perhaps affects the kind of discursive research in the NHS where clinicians make the first approach to service users. I ensured that the care co-ordinators who took part understood the research by explaining the research and having them explain it back to me. They also asked further clarifying questions, and were self-selected as participants so had an interest in what the study could potentially reveal from the start.

6. Conclusion

There were many layers of self-selection that participants passed through before their meetings were recorded as part of the study. The team had to agree to take part, each care co-ordinator had to agree to take part, the care co-ordinator then selected service users to approach, the service user had to agree and then the psychiatrist had to agree. This filtering process means a very specific sub-set of participants were eventually recruited to take part. This process was necessary from an ethical standpoint, however it did give me cause to reflect from the angle of data collection. I couldn't help but wonder about the teams that didn't take part, the professionals who didn't want to take part, the service users who weren't deemed suitable to be asked to take part. What was the story of these teams and individuals? Would the meetings they were a part of be similar or different to the ones I had collected? Though the sampling described could be an issue to studies that rely on a statistical or aggregate view of order, it can be thought of as of less concern to the discursive researcher. Schegloff (1992 cited in McCarthy & Rapley, 2001) explains Harvey Sacks explanation on this as the view that order also exists at all points. Put

succinctly this view suggests that ‘a culture is not then to be found only by aggregating all of its venues; it is substantially present in each of its venues’ (Schegloff, 1992 cited in McCarthy & Rapley, 2001, p161). So, although not necessarily an issue methodologically, my feeling clinically is that there may be potentially interesting features of CPA review meetings not seen in the corpus obtained for this study.

Another team meeting proved to be challenging as a couple of attendees attempted to re-specify my study in terms of dependent and independent variables. It appeared that essentially people were attempting to integrate what I was suggesting into their own understanding of research. This was quite frustrating at the time and I tried to resist this and explain the rationale and method as best I could. This was difficult when discussing research with experienced clinicians who ‘know what research is’, and who have the power to make their definitions stick. The episode was a reminder to me of the hierarchical system that can prevail in some NHS teams with certain more ‘powerful’ voices dominating proceedings and having their understandings carry the day. I reflected on how the interaction could have played out differently and considered the idea of some kind of teaching session delivered to the staff as I explained the research. Teaching sessions could also be delivered to ethics committees to increase their knowledge in the same way. The level of knowledge about discursive research in the NHS is, in my experience, low and so staff teams may require more information about the nature of the method than for other more familiar approaches.

Thinking as a clinician-researcher the practical applications of research are always close to mind. I feel there is a strong ethical obligation that if research of whatever kind is conducted in a health setting, then it should be linked where possible to improving practice and ultimately care for the service user. There are areas of potential difficulty facing the researcher pursuing discursive research in the NHS, as reflected upon in this paper. However interactions between professionals and service users occur in the NHS millions of times every day and they can be the cause of complaint by service users and family members. Recent media coverage of MP Ann Clwyd's complaint against the NHS in Wales contains allegations of staff showing what she describes as 'indifference' and 'callousness' (British Broadcasting Corporation, 2014) which are phenomena that could potentially be studied discursively to look in detail at the interactions in question. The opportunity for discursive research to directly influence the lives of people living and working in NHS settings is apparent and it could potentially make a difference to the way that care is delivered and outcomes for service users.

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APPENDIX A

Applied Psychological Research – Author Guidelines

Author Guidelines

All manuscripts should be prepared using the 6th Edition of the publication manual of the American Psychological Association (APA, 2009). This format should be applied to all aspects of the manuscript, including as an absolute minimum:

- Title page (for blind peer review)
- Abstracts
- Keywords
- Levels of heading
- Tables
- In-text citations
- Reference lists
- Anti-discriminatory language

All submissions should be written in an accessible style that can be understood by both students and practitioners. All jargon should be defined clearly if used at all and authors are encouraged to avoid using jargon wherever possible.

Documents should be processed using a word-processing package (e.g MS Word) and not submitted as PDFs.

Page numbers should be included on all pages of every manuscript submitted to the journal. Articles must be prepared using 12 point Times New Roman or Cambria font and 1.5 line spacing.

ORIGINAL RESEARCH ARTICLES

Articles should report the findings of completed original or replicated research studies. Preliminary findings or the findings from pilot studies will be considered under the 'short report' submission criteria detailed below.

Ideally, reports of original research that employ quantitative methodologies should not exceed 5000 words. Those employing qualitative or mixed qualitative and quantitative methodologies should not exceed 7000 words. After consultation with the Editor, longer manuscripts may be considered if a clear case for the length can be made. However the emphasis should be on clarity and conciseness of writing. The word limit **does not** include tables and reference lists; neither does it include verbatim extracts from qualitative sources. It does however include in-text citations.

Articles should include appropriate reference to the theoretical and practice context throughout. Findings should make reference explicitly to the implications for practice. Indeed at the end of the manuscript three bullet points must be presented in which the most important implications for practice are summarized. These points must not exceed 150 words in total.

Ideas for special issues/sections of the journal are welcome, and individuals with such an idea are encouraged to contact the Editor-in-Chief (Dr Erica Bowen) or

the Deputy (Dr Simon Goodman) in the first instance to discuss these ideas further.

LITERATURE REVIEW ARTICLES

Articles should synthesize existing literature using either qualitative (narrative), quantitative (meta-analytical) or systematic reviewing approaches. The reviews must examine literature that has clearly stated and identified implications.

Literature review articles ideally should not exceed 7000 words. The word limit **does not** include tables and reference lists; neither does it include verbatim extracts from qualitative sources. It does however include in-text citations.

At the end of the manuscript three bullet points must be presented in which the most important implications for practice are summarized. These points must not exceed 150 words in total.

SHORT REPORTS

Short reports should provide summaries of the most important findings from either preliminary or pilot studies using qualitative, quantitative or mixed methodologies.

Short reports should not exceed 2500 words. The word limit **does not** include tables and reference lists; neither does it include verbatim extracts from qualitative sources. It does however include in-text citations.

At the end of the manuscript three bullet points must be presented in which the most important implications for practice are summarized. These points must not exceed 150 words in total.

PRACTICE NOTES

Practice notes function to summarize an aspect of psychological theory with a view to providing clear direction for practitioners. For example, an article in which adult attachment theory is summarized within the context of offender rehabilitation, with clear implications for how intervention sessions at different phases of intervention might be designed.

Practice notes should not exceed 3500 words. The word limit **does not** include reference lists. It does however include in-text citations.

IMPACT NOTES

Impact notes lead on from practice notes in that they are written in order to illustrate how aspects of psychological research have directly influenced practice

in a particular area. Consequently, the above example at this point might represent a practitioner view of how empirical findings relating to adult attachment theory have been interpreted and used to inform intervention approaches with offenders, and evidence of its impact might also be reported (e.g. preliminary evaluation data).

Impact notes should not exceed 4000 words. The word limit **does not** include tables and reference lists; neither does it include verbatim extracts from qualitative sources. It does however include in-text citations.

RESPONSE PAPERS

The journal encourages response papers which provide measured commentaries and/or evidence-based opinion on previously published work in any section of the journal. The papers should encourage and represent healthy academic debate which ultimately furthers knowledge and understanding of the topic or policy examined. All papers are to be written in an appropriate academic jargon-free tone.

Response papers should not exceed 2500 words. The word limit **does not** include tables and reference lists; neither does it include verbatim extracts from qualitative sources. It does however include in-text citations.

POLICY REVIEWS

Given the relevance of public policy to psychological practice, we invite authors to consider providing policy reviews. Such articles should provide the context of the relevant policy, either aspects of particular relevance for psychological practice, or how policies have changed or their relevance for practice. These reviews should be written for a largely non-academic audience, focusing particularly on practitioners.

Policy reviews should not exceed 5000 words. The word limit **does not** include tables and reference lists. It does however include in-text citations.

Submission Preparation Checklist

As part of the submission process, authors are required to check off their submission's compliance with all of the following items, and submissions may be returned to authors that do not adhere to these guidelines.

1. The submission has not been previously published, nor is it before another journal for consideration (or an explanation has been provided in Comments to the Editor).
2. The submission file is in OpenOffice or Microsoft Word
3. Where available, DOIs for the references have been provided.
4. The text is double-spaced; uses a 12-point font; employs italics, rather than underlining (except with URL addresses); and the placement of all illustrations, figures, and tables are indicated within the text at the

appropriate points, and the illustrations, figures and tables are at the end of the manuscript after the references section.

5. The text adheres to the stylistic and bibliographic requirements outlined in the [Author Guidelines](#), which is found in About the Journal.
6. The instructions in [Ensuring a Blind Review](#) have been followed.

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APPENDIX B

Qualitative Research in Psychology - Manuscript Guidelines

This journal uses ScholarOne Manuscripts (previously Manuscript Central) to peer review manuscript submissions. Please read the [guide for ScholarOne authors](#) before making a submission. Complete guidelines for preparing and submitting your manuscript to this journal are provided below.

Aims and Scope. *Qualitative Research in Psychology* aims to become the primary forum for qualitative researchers in all areas of psychology—cognitive, social, developmental, educational, clinical, health, and forensic—as well as for those conducting psychologically relevant qualitative research in other disciplines.

Qualitative Research in Psychology is dedicated to exploring and expanding the territory of qualitative psychological research, strengthening its identity within the international research community and defining its place within the undergraduate and graduate curriculum. The journal will be broad in scope, presenting the full range of qualitative approaches to psychological research. The journal aims to firmly establish qualitative inquiry as an integral part of the discipline of psychology; to stimulate discussion of the relative merits of different qualitative methods in psychology; to provide a showcase for exemplary and innovative qualitative research projects in psychology; to establish appropriately high standards for the conduct and reporting of qualitative research; to establish a bridge between psychology and the other social and human sciences where qualitative inquiry has a proven track record; and to place qualitative psychological inquiry appropriately within the scientific, paradigmatic, and philosophical issues that it raises.

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Types of Manuscripts. *Qualitative Research in Psychology* will publish the following types of paper:

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- 3) Debates
- 4) Book reviews

Submissions for special issues will normally be announced via an advertisement in the journal, although suggestions for topics are always welcome. Book reviews will normally be suggested by the Reviews Editor, although unsolicited reviews will be considered. The journal will also review other relevant media as well as qualitative research software.

All papers are refereed by, and must be to the satisfaction of, at least two authorities in the topic. All material submitted for publication is assumed to be exclusively for *Qualitative Research in Psychology*, and not to have been submitted for publication elsewhere. Priority and time of publication are decided by the editors, who maintain the customary right to edit material accepted for publication if necessary.

Submission of Manuscripts. *Qualitative Research in Psychology* receives all manuscript submissions electronically via its ScholarOne Manuscripts site located at <http://mc.manuscriptcentral.com/uqrp>. ScholarOne Manuscripts allows for rapid submission of original and revised manuscripts, and facilitates the review process and internal communication between authors, editors, and reviewers via a web-based platform. ScholarOne technical support can be accessed at <http://scholarone.com/services/support>. Authors should upload three files in total: a separate title page with author names and institutional affiliations, a blinded main document, and a separate document for any tables and figures. The editorial office accepts papers in either UK or US page size formats.

Manuscripts should be double-spaced throughout, especially the references. Pages should be numbered in order. The following items must be provided in the order given:

1) Title Page .

Authors and affiliations: Authors should include their full name and the establishment where the work was carried out (if the author has left this establishment, his/her present address should be given as a footnote). For papers with several contributors, the order of authorship should be made clear and the corresponding author (to whom proofs will be sent) named with their telephone/fax/e-mail contact information listed.

Abstract: Please provide an abstract of approximately 150 words. This should be readable without reference to the article and should indicate the scope of the contribution, including the main conclusions and essential original content.

Keywords: Please provide at least 5–10 key words.

About the author: Please provide a brief biography to appear at the end of your paper.

2) Text.

Subheadings should appear on separate lines. The use of more than three levels of heading should be avoided. Format as follows:

1 Heading

1.1 Subheading

1.1.1 Subsubheading

Footnotes should be avoided. If necessary, they should be supplied as end notes before the references.

3) References.

The Harvard style of references should be used. The reference is referred to in the text by the author and date (Smith, 1997) and then listed in alphabetical order at the end of the article applying the following style:

For a book: Hollway, W & Jefferson, T 2000, *Doing qualitative research differently: free association, narrative and the interview method*, Sage, London.

For an edited book: Brown, LM 2001, 'Adolescent girls, class, and the cultures of femininity', in MJ Packer & MB Tappan (eds.), *Cultural and critical perspectives on human development*, SUNY Press, Albany, NY, pp. 219–240.

For a journal article: Madill, A, Jordan, A and Shirley, C 2000, 'Objectivity and reliability in qualitative analysis: realist, contextualist and radical constructionist epistemologies', *British Journal of Psychology*, vol. 91, pp. 1–20.

4) Acknowledgements.

Authors should acknowledge any financial or practical assistance.

5) Tables.

These should be provided in a separate file from the text and should be numbered in sequence. Each table should have a title stating concisely the nature of information given. Units should be in brackets at the head of columns. The same information should not be included in both tables and figures.

6) Figure captions.

These should be provided together on a page following the tables.

7) Figures.

Figures should ideally be sized to reproduce at the same size. All figures should be numbered consecutively in the order in which they are referred to in the text.

Qualifications (A), (B), etc., can only be used when the separate illustrations can be grouped together with one caption. Please provide figures at the end of your paper on a separate page for each figure. Once accepted, you will be required to provide a best quality electronic file for each figure, preferably in either TIFF or EPS format.

Illustrations. Illustrations submitted (line drawings, halftones, photos,

photomicrographs, etc.) should be clean originals or digital files. Digital files are recommended for highest quality reproduction and should follow these guidelines:

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APPENDIX C

Participant Information Sheet - Professionals



PARTICIPANT INFORMATION SHEET - (Professionals)

Title of the Project: Identity Construction in Care Programme Approach (CPA) Review Meetings.

Name of Principal Researcher: Paul Matthews, Trainee Clinical Psychologist.

I am carrying out research to find out more about the process of care programme approach (CPA) review meetings. In order to look carefully at who says what to whom and how this is done I need to make an audio recording of the meeting.

Why have I been asked to take part?

I am asking service users and professionals who attend CPA meetings for their informed consent to digitally audio record the meeting. I am asking people who are part of the CPA process in community services run by Coventry & Warwickshire Partnership NHS Trust.

What is the study's purpose?

The purpose of the study is to look carefully at the communication in CPA meetings. The focus of the study is on what service users and professionals say in meetings and how this takes place.

What would I have to do?

All you need to do is give your informed consent for the meeting which you are a part of to be audio recorded. You don't have to do anything differently in the meeting, just act as you would normally do.

Do I have to take part?

You do not have to take part. The decision to take part is voluntary and if you choose not to take part you do not have to give a reason. You will not be affected in any way if you choose not to take part.

How do I withdraw my consent?

You are free to withdraw your consent at any time up to one calendar month after the date of recording without giving a reason. The time limit of one month for you to withdraw consent is necessary for me to ensure I have enough data to submit for my thesis in May 2014. If you are employed by an NHS organisation this will not affect your current employment in any way. You can contact any member of the research team to withdraw your consent (details below). All audio and written transcript data will be destroyed.

How will my data be protected?

Information will be handled in line with the Data Protection Act 1998. All data will be stored securely in locked cabinets. All data will be confidential within the research team and used for the sole purpose of the current study. Regulatory bodies may need access to some parts of the data. These bodies are also bound by a code of confidentiality regarding your data. Once the study is complete, data will be kept securely at Coventry University for 5 years before being destroyed.

What will happen to the results of this audio recording?

I will turn the recording into a written document, like a script. In doing this I will remove all names and other information that would identify you in the text. These documents will form the basis of my study, the results of which will be written up as part of my thesis in May 2014. I will analyse the script using a method called

'discourse analysis' which looks at the way that conversations work. In this research I will be using discourse analysis to see how effective the review meetings are in supporting the people who attend them.

The material may then be submitted for publication in a psychological journal so that the results can be used by other people. I may use quotations from the script of the recording in material that is submitted for publication or presented to others. Any information that could identify you in these quotations will be removed.

How can I access the results of the study?

Following the submission of my thesis in May 2014, I will make a review of the findings accessible to you through the research pages of the Coventry & Warwickshire Partnership NHS Trust website. This will be available by the end of June 2014. If you would prefer a written paper document of the findings you can contact the Principal Researcher (details below) with your contact details and I will send you a summary via post. If a staff team taking part in the study would like a presentation of the findings in their service this can also be arranged in the period June-September 2014.

What are possible risks of taking part?

Knowing that the meeting that you are of a part of is being tape recorded could make you feel uncomfortable or unable to say what you want to say. You can say that you want to stop the recording at any time without giving a reason.

What are the possible benefits to taking part?

It cannot be assured that the study will be of any help to you directly, but the information from it could be helpful to clinicians who take part in CPA review meetings in the future.

Who has reviewed the study?

The study has been approved by Coventry University ethics committee, NHS Ethics and the local NHS Research & Development department.

Any more questions?

If you have any questions about the study, please do not hesitate to contact the Principal Researcher or another member of the research team using the contact details below.

What do I do if I want to take part?

If you do want to take part it would be helpful if you could contact the Principal Researcher to say that you would like to. In order to get your written consent to take part in the study it would be helpful if you could attend the CPA review meeting between **30 and 10 minutes earlier** than the scheduled time for the meeting.

Who are the research team members and how can I contact them?

Principal Researcher: Paul Matthews, Trainee Clinical Psychologist, Clinical Psychology Doctorate, Coventry University, Priory Street, CV1 5FB. E –mail: matthe66@coventry.ac.uk.

Dr Helen Liebling, Lecturer-Practitioner in Clinical Psychology, Coventry University, Priory Street, CV1 5FB. E –mail: hsx497@coventry.ac.uk.

Dr Simon Goodman, Senior Lecturer in Psychology, Coventry University, Priory Street, CV1 5FB. E –mail: simon.goodman@coventry.ac.uk

APPENDIX D

Participant Information Sheet – Service Users



PARTICIPANT INFORMATION SHEET - (Service Users)

Title of the Project: Identity Construction in Care Programme Approach (CPA) Review Meetings.

Name of Principal Researcher: Paul Matthews, Trainee Clinical Psychologist.

I am carrying out research to find out more about the process of care programme approach (CPA) review meetings. In order to look carefully at who says what to whom and how this is done I need to make an audio recording of the meeting.

Why have I been asked to take part?

I am asking service users and professionals who attend CPA meetings for their informed consent to digitally audio record the meeting. I am asking people who are part of the CPA process in community services run by Coventry & Warwickshire Partnership NHS Trust.

What is the study's purpose?

The purpose of the study is to look carefully at the communication in CPA meetings. The focus of the study is on what service users and professionals say in meetings and how this takes place.

What would I have to do?

All you need to do is give your informed consent for the meeting which you are a part of to be audio recorded. You don't have to do anything differently in the meeting, just act as you would normally do.

Do I have to take part?

You do not have to take part. The decision to take part is voluntary and if you choose not to take part you do not have to give a reason. Your support from Coventry & Warwickshire Partnership NHS Trust will not be affected in any way if you choose not to take part.

How do I withdraw my consent?

You are free to withdraw your consent at any time up to one calendar month after the date of recording without giving a reason. The time limit of one month for you to withdraw consent is necessary for me to ensure I have enough data to submit for my thesis in May 2014. You can contact any member of the research team to withdraw your consent (details below). This will not affect your current support by services in any way. All audio and written transcript data will be destroyed. If you lose the capacity to consent to take part during the study period then you will be withdrawn from the study but any data already taken will still be used.

How will my data be protected?

Information will be handled in line with the Data Protection Act 1998. All data will be stored securely in locked cabinets. All data will be confidential within the research team and used for the sole purpose of the current study. Regulatory bodies may need access to some parts of the data. These bodies are also bound by a code of confidentiality regarding your data. Once the study is complete, data will be kept securely at Coventry University for 5 years before being destroyed.

What will happen to the results of this audio recording?

I will turn the recording into a written document, like a script. In doing this I will remove all names and other information that would identify you in the text. These documents will form the basis of my study, the results of which will be written up as part of my thesis in May 2014. I will analyse the script using a method called

‘discourse analysis’ which looks at the way that conversations work. In this research I will be using discourse analysis to see how effective the review meetings are in supporting the people who attend them.

The material may then be submitted for publication in a psychological journal so that the results can be used by other people. I may use quotations from the script of the recording in material that is submitted for publication or presented to others. Any information that could identify you in these quotations will be removed.

How can I access the results of the study?

Following the submission of my thesis in May 2014, I will make a review of the findings accessible to you through the research pages of the Coventry & Warwickshire Partnership NHS Trust website. This will be available by the end of June 2014. If you would prefer a written paper document of the findings you can contact the Principal Researcher (details below) with your contact details and I will send you a summary via post.

What are possible risks of taking part?

Knowing that the meeting that you are a part of is being tape recorded could make you feel uncomfortable or unable to say what you want to say. You can say that you want to stop the recording at any time without giving a reason.

What are the possible benefits to taking part?

It cannot be assured that the study will be of any help to you directly, but the information from it could be helpful to clinicians who take part in CPA review meetings in the future.

Who has reviewed the study?

The study has been approved by Coventry University ethics committee, NHS Ethics and the local NHS trust Research & Development department.

Any more questions?

If you have any questions about the study, please do not hesitate to contact the Principal Researcher or another member of the research team using the contact details below. If you would like to speak about the research with somebody who is not part of the study, you can contact the Patient Advice and Liaison Service (PALS). The contact details for PALS in Coventry and Warwickshire Partnership NHS Trust are:

Patient Advice and Liaison Service (PALS),
Coventry and Warwickshire Partnership NHS Trust,
Wayside House,
Wilsons Lane,
Coventry,
CV6 6NY.
Tel: 02476 536804
Text message: 07826 900926
E-mail: pals@covwarkpt.nhs.uk

What do I do if I want to take part?

If you do want to take part it would be helpful if you could contact the Principal Researcher (or your Care Coordinator) to say that you would like to. In order to get your written consent to take part in the study it would be helpful if you could attend the CPA review meeting between **30 and 10 minutes earlier** than the scheduled time for the meeting.

Who are the research team members and how can I contact them?

Principal Researcher: Paul Matthews, Trainee Clinical Psychologist, Clinical Psychology Doctorate, Coventry University, Priory Street, CV1 5FB. E –mail: matthe66@coventry.ac.uk.

Dr Helen Liebling, Lecturer-Practitioner in Clinical Psychology, Coventry University,
Priory Street, CV1 5FB. E –mail: hsx497@coventry.ac.uk.

Dr Simon Goodman, Senior Lecturer in Psychology, Coventry University, Priory
Street, CV1 5FB. E –mail: simon.goodman@coventry.ac.uk

APPENDIX E

Participant Consent Form

Coventry and Warwickshire 
Partnership Trust

INFORMED CONSENT FORM

Title of the Project: Identity Construction in Care Programme Approach (CPA)

Review Meetings.

Name of Principal Researcher: Paul Matthews, Trainee Clinical Psychologist.

Please read the points below and initial each box to indicate that you agree before signing overleaf.

☐

I confirm that I have read and understood the Participant Information Sheet (dated 24/08/13, version 1) for the above study and have been given the opportunity to ask any questions or raise any issues with the researcher.

☐

I give permission for the Care Programme Approach (CPA) review meeting of which I am a part to be digitally recorded, transcribed and used anonymously for the purposes of research.

☐

I give permission for the data I give to be discussed with the wider research team consisting of the Principal Researcher and the other members of the research team.

I understand the following:

☐

The audio recording of the CPA meeting and transcript will be stored securely. The recording will be destroyed upon completion of the study and the transcript will be kept securely for 5 years at Coventry University before being destroyed.

☐

That my name will be removed from all transcript data. I will not be identifiable in any data used in the final study or material used for publication.

☐

That my participation is voluntary and I can withdraw my consent at any time up to one calendar month after the date of recording. If I lose the capacity to consent during the study period I will be withdrawn from the study, but any data already collected will be retained and may be used in the study.

☐

That my healthcare / employment* with Coventry & Warwickshire Partnership NHS Trust will not be affected by my participation in the study. (*Please delete as appropriate).

Signed:

Participant name:

Participant signature.....

Date.....

Name of Person taking Consent:.....

Person taking Consent signature:

APPENDIX F

Approval Letter from Coventry University Ethics

TO WHOM IT MAY CONCERN

QRS/Ethics/Sponsorlet

Monday, 08 July 2013

Dear Sir/Madam

Researcher's name: Paul Matthews

Project Reference: P11665

Project Title: Identity construction in care programme approach (CPA) meetings.

The above named student has successfully completed the Coventry University Ethical Approval process for his project to proceed.

I should like to confirm that Coventry University is happy to act as the sole sponsor for this student and attach details of our Public Liability Insurance documentation.

With kind regards

Yours faithfully



Professor Ian Marshall

Deputy Vice-Chancellor, Academic

Enc

APPENDIX G

Approval Letter from NHS Ethics

NRES Committee West Midlands - Edgbaston

The Old Chapel
Royal Standard Place
Nottingham
NG1 6FB

Telephone: 0115 8839525

28 October 2013

Mr Paul I Matthews
Trainee Clinical Psychologist
Coventry & Warwickshire Partnership NHS Trust
Department of Clinical Psychology
James Starley Building
Priory Street, Coventry
CV1 5FB

Dear Mr Matthews

Study title:	Identity Construction by Service Users and Professionals in Care Programme Approach (CPA) Review Meetings: A Discourse Analysis.
REC reference:	13/WM/0411
IRAS project ID:	126836

The Research Ethics Committee reviewed the above application at the meeting held on 18 October 2013. Thank you for attending to discuss the application.

We plan to publish your research summary wording for the above study on the NRES website, together with your contact details, unless you expressly withhold permission to do so. Publication will be no earlier than three months from the date of this favourable opinion letter. Should you wish to provide a substitute contact point, require further information, or wish to withhold permission to publish, please contact the Co-ordinator Miss Helen Wakefield, at nrescommittee.westmidlands-edgbaston@nhs.net.

Ethical opinion

- The committee asked you who the people attending the meeting would be and you advised they would be members of a multidisciplinary team and the service user.
- The committee asked if the venue would be familiar to the service users and you confirmed that it would.
- The committee asked if you had considered the acoustics of the rooms to be used and you said that although you had not had previous experience you suggested that this would not be an issue.
- The committee asked if you felt there is a particular problem within this area of therapy and you said that there seemed to be a gap between what the official guidance proposed and what happened in practice.

- The committee questioned if the care coordinators identifying participants could introduce bias to the sample. You acknowledged that it might but it would still be a good first attempt to assess what goes on in these meetings.
- The committee wanted to know if the researcher thought the process for informing potential participants was adequate and you said you are prepared to modify it if necessary.
- The committee wanted to know if you would be able to identify who was speaking when transcribing the meetings and you said that you are confident that you will, based on previous experience.
- The committee discussed the anonymisation process which was satisfactory.
- The committee asked if the data would be safe on a home computer. You were confident that it would be and you stated you would back it up so that it was not accidentally lost or stolen.
- The committee noted that the Participant Information Sheets were less forthcoming than the application form and protocol about the purpose of the study but it was satisfied that the level of deception was acceptable.
- The committee suggested explaining to the participants why they will be able to withdraw from the study up to one calendar month, that is, until the data is analysed.
- The committee suggested mentioning in the Participant Information Sheet that you will not be present during the recording of the interviews.
- The committee wanted to know if by not being present at the meetings you would miss significant non-verbal communication. You informed the committee that you are only looking at the verbal interaction between participants.
- The committee questioned what would happen if one participant did not want to take part and if they had a right of veto over the whole group. You informed the committee that they would, and that the meeting would not be included in the study.

The members of the Committee present gave a favourable ethical opinion of the above research on the basis described in the application form, protocol and supporting documentation, subject to the conditions specified below.

Ethical review of research sites

NHS Sites

The favourable opinion applies to all NHS sites taking part in the study, subject to management permission being obtained from the NHS/HSC R&D office prior to the start of the study (see "Conditions of the favourable opinion" below).

APPENDIX H

Local NHS Research and Development Approval Letter

Coventry and Warwickshire Partnership Trust

West Midlands (South) Comprehensive Local Research Network
Fourth Floor, West Wing (ACF40002)
University Hospitals Coventry & Warwickshire NHS Trust
University Hospital
Clifford Bridge Road
Coventry
CV2 2DX

29th November 2013

Mr Paul Matthews
Department of Clinical Psychology
James Starley Building
Priory Street
Coventry
CV1 5FB

Dear Mr Matthews

**Project Title: Construction in Care Programme Approach Review (CPA)
Meetings
R&D Ref: PAR301013
REC Ref: 13\WM/0411**

I am pleased to inform you that the R&D review of the above project is complete, and NHS permission has been granted for the study at Coventry and Warwickshire Partnership NHS Trust. The details of your study have now been entered onto the Trust's database.

The permission has been granted on the basis described in the application form, protocol and supporting documentation. The documents reviewed were:

Document	Version	Date
REC Favourable Opinion Letter	13/WM/0411	28.10.2013
Protocol	2.0	19.09.2013
Participant Information Sheet (Professionals)	1.0	24.08.2013
Participant Information Sheet (Service Users)	1.0	24.08.2013
Informed Consent Form	1.0	24.08.2013
Letter	1.0	24.08.2013
R and D Form	126836/514549/14/304	14.10.2013
SSi Form	126836/510411/6/198/195796/282701	08.10.2013

All research must be managed in accordance with the requirements of the Department of Health's Research Governance Framework (RGF), to ICH-GCP standards (if applicable) and to NHS Trust policies and procedures. Permission is only granted for the activities agreed by the relevant authorities.

All amendments (including changes to the local research team and status of the project) need to be submitted to the REC and the R&D office in accordance with the guidance in IRAS. Any urgent safety measures required to protect research participants against immediate harm can be implemented immediately. You should notify the R&D Office within the same time frame as any other regulatory bodies.

It is your responsibility to keep the R&D Office and Sponsor informed of all Serious Adverse Events. All SAEs must be reported within the timeframes detailed within ICH-GCP statutory instruments and EU directives.

In order to ensure that research is carried out to the highest governance standards, the Trust employs the services of an external monitoring organisation to provide assurance. Your study may be randomly selected for audit at any time, and you must co-operate with the auditors. Action may be taken to suspend Trust approval if the research is not run in accordance with RGF or ICH-GCP standards, or following recommendations from the auditors.

You will be sent an annual progress report which must be completed in order to ensure that the information we hold on our database remains up to date, in line with RGF requirements.

I wish you well with your project. Please do not hesitate to contact me should you need any guidance or assistance.

Yours sincerely



Natassia Embury
R&D Facilitator

Cc: Dr Helen Liebling-Kalifani, Academic Supervisor
Dr Simon Goodman, Academic Supervisor
Sally Robbins, Head of Psychology in Secondary Care

APPENDIX I

Stages of Analysis

1. Recordings were transcribed using the system referenced in Chapter 2.
2. Recordings were listened to again with reference to the transcript and amendments made. Questions in the recordings were identified with reference to both the recording and the transcript.
3. Each question in the transcript was explored in terms of the action being performed. Attention was paid to the preceding turns and the response to identify the interactional context.
4. Incidences of similar actions being performed were collated, recorded and the transcript lines noted.
5. Collections of transcript sections were examined in further detail to assess issues of stake and accountability for the speakers.

APPENDIX J

Extended section of Transcript

P2: Well we're paying, we are covering the bills but it's a struggle. Yeah.

P1: So are we getting taxis or the bus.

P2: No, getting the bus (0.7) erm for instance yesterday, I think I had to bring me brother up the road for an x ray and caught the bus rather than getting a taxi.

P1: Yeah, yeah, but do you get your booze [going by taxi.

P2: [Erm no its sort of I've been going on the bus actually, so

P1: yeah yeah

P2: I mean there has been the occasional taxi but erm (.) but sort of generally speaking I go on the bus

P1: So are we buying food aswell as ↑booze=

P2: =Food yeh

P3: Going to Aldi aren't we.

P2: Yes, yeah (P3 name) kindly took me shopping to aldi and got a .hh quite a bit actually didn't we for six, seven pounds, quite good.

P3: Yeah yeh.

P1: Mmm, mmm, yeh, well good. So it's Mum spent it all going to Iceland (laughs).
(2.5)

P2: Well erm yeah °we have er°

P1: Well we'll cut down to six, how much of a struggle is that.

P2: Erm (0.8) it's it's a bit of a struggle yeah.

P1: >What's the struggle then<

P2: Pacing it out

(1.2)

P1: What, when do you have your first drink.

P2: Erm (.) well I know on two or three occasions that I've last seen you (coughs)
I've said eleven o'clock (swallows) erm I've pushed it back to about twelve o'clock
now (.) so

(3.0)

P1: Why do you have it at twelve o'clock=

P2: =Why do I have it at twelve o'clock (4.3) °er° I don't know cos I want one
real(hh)ly

P1: [Argh but do you start getting erm (.) shakes er

P3: [°but why do you°

(0.5)

P2: No (.) I sorta get (2.0) it's probably dehydration (.) and sort of feel that I need
yeh a (.) a can to rehydrate myself but=

P1: =↑So er what other things do you have in the house that you could rehydrate
yourself with=

P2: =water, [squash, tea

P1: [°water, squash, tea yeah°

P2: °yeh°

P1: °Coffee°

P2: °Coffee, yeh°

P1: °yeh (.) er can do that°

P2: Er I Can do, I had a cup of coffee this morning yeh.

P1: Go for a ↑walk

P2: Go for a ↑walk yeah

P1: So you're not having any alcohol

P2: ↑Yeh

P1: Mmm

(2.4)

P1: °so°

P3: It's a long day isn't it really=

P2: =It is a long day yeh yeah.

APPENDIX K

Qualitative Methods in Psychology Bulletin – Instructions for Authors

Qualitative Methods in Psychology Bulletin: Instructions for authors

QMIP Bulletin is published on behalf of the British Psychological Society Qualitative Methods in Psychology Section, and welcomes submissions on any aspect of qualitative psychology. The Editorial Board are keen to encourage concise, focussed articles which may be somewhat shorter than would be found in other publications in the field. Submissions are invited under the following broad categories:

Theory, Method, Research and Pedagogy: Peer-reviewed articles and Brief reports

Articles dealing with theoretical, methodological and/or empirical matters are particularly welcomed, as are literature reviews. The Editorial Board would also like to encourage submissions dealing with pedagogical aspects of qualitative methods in psychology.

Longer articles dealing with substantive issues should typically be between 2000 and 4000 words in length, and will be sent for peer-review to at least two expert reviewers.

Brief articles or comments (up to 2000 words) are also encouraged. It is not currently the policy of the Editorial Board to send these for peer-review, and as such these articles will be dealt with by a member of the Editorial Board.

In all cases, the Editorial Board will make an initial decision regarding the suitability of articles for publication in *QMIP Bulletin*.

Events

One of the primary functions of *QMIP Bulletin* is to provide a platform for publicising and reviewing events. Submissions of this nature should be no longer than 2000 words, and would typically be substantially shorter than this.

Book Reviews should be no longer than 2000 words.

In all cases, the Editorial Board reserves the right to relax word limits where appropriate, and to edit manuscripts if necessary.

Manuscript preparation

Manuscripts should be prepared according to the British Psychological Society's *Style Guide* (see www.bps.org.uk/sites/default/files/images/bps_style_guide.pdf).

Authors are requested to pay particular attention to this when preparing references lists. All submissions should be in English.

Manuscripts should be double-spaced throughout, and should incorporate page numbers. The title page should include the full title of the manuscript, author name(s), institutional affiliations and contact details.

Authors submitting their work for peer-review should submit two versions of their manuscript: one with identifying information provided, and a second anonymised version.

All articles except for **Events** and **Book Reviews** should be preceded by an abstract of 100 to 150 words for longer articles, and 50 to 100 words for brief reports.

Manuscript submission

All contributions should be submitted by email to the Editor, Victoria Tischler (victoria.tischler@nottingham.ac.uk). Submissions should be in Microsoft Word format.